DEPARTMENT OF HEALTH & HUMAN SERVICES

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

FEB 0 1 2018

CERTIFIED MAIL

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

Novitas Solutions, Inc.
Mounir Kamal
Director JH, Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Baylor Medical Center at Irving
Provider No.: 45-0079
FYE: 6/30/2008, 2010, 2011, & 2012
PRRB Case Nos.: 13-0817, 14-2846, 14-4108, & 15-0441

Dear Mr. Ravindran and Mr. Kamal,

The Provider Reimbursement Review Board ("PRRB" or "the Board") has reviewed the documents in each of the above-referenced appeals for Baylor Medical Center at Irving. The Board has determined that it does not have jurisdiction over the SSI Provider Specific issue in any of the above-referenced appeals. The Board's decision is set forth below.

Background

Baylor Medical Center at Irving timely appealed from an original Notice of Program Reimbursement ("NPR") for each of the following fiscal years: 6/30/2008, 6/30/2010, 6/30/2011, and 6/30/2012 and the Board established the following appeals: 13-0817; 14-2846; 14-4108; and 15-0441. The Provider appealed various issues in each appeal, and has since transferred issues to group appeals and withdrawn other issues. Two issues remain pending in each appeal: SSI Provider Specific and Medicaid Eligible Days.

The Provider appealed the SSI Systemic Errors issue in all of its individual appeal requests and later requested to transfer the issue to the following group appeals: 13-3933GC (QRS BHCS 2008 DSH SSI Percentage CIRP Group); 15-0360GC (QRS BHCS 2010 DSH SSI Percentage CIRP Group); 15-0733GC (QRS BHCS 2011 DSH SSI Percentage CIRP Group); and 15-3173GC (BHCS 2012 DSH SSI Percentage CIRP Group).

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

The first aspect of the issue—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was transferred to various groups and is dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Provider's legal basis for Issue No. 1 also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[3] The Provider argues that "its SSI percentage published by [CMS] was incorrectly computed . . . ." and it ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Provider's Systemic Errors issue is "[whether] the Secretary properly calculated the Provider's Disproportionate Share Hospital/Supplemental Security Income percentage."[5] Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has filed directly into group appeals.

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

Because the Systemic Errors issue was transferred to CIRP group appeals, the Board dismisses this aspect of the SSI Provider Specific issue.

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[1] *See* Providers' Individual Appeal Requests at Tab 3.
[2] *Id.* at Tab 3, Issue 1.
[3] *Id.*
[4] *Id.*
[5] *Id.* at Tab 3, Issue 2.

The second aspect—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.

Conclusion

The Board finds that it lacks jurisdiction over the SSI Provider Specific issue for Baylor Medical Center at Irving in case numbers 13-0817, 14-2846, 14-4108, and 15-0441 and hereby dismisses the issue from each of these appeals. The appeals remain open as the Medicaid eligible days issue is pending in each appeal.

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

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

FOR THE BOARD

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

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

cc: Wilson Leong, FSS

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Laurie Polson, Appeals Lead
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P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Jurisdictional Decision
Provider: Cape Fear Valley Medical Center
Case Number: 14-0725
FYE: 09/30/2008

Dear Mr. Ravindran and Ms. Polson:

Background

Cape Fear Valley Medical Center ("Provider") is appealing the amount of Medicare reimbursement determined by its Medicare Contractor in a Notice of Program Reimbursement ("NPR") dated May 16, 2013. The Provider filed a timely appeal from the NPR on November 13, 2013. The appeal request contained the following twelve issues:

1) Issue No. 1 regarding Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)("DSH/SSI Percentage (Provider Specific)"),
2) Issue No. 2 regarding Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI")(Sytemic Errors) ("DSH/SSI Systemic Errors")),
3) Issue No. 3 regarding Disproportionate Share Hospital Payment – Medicaid Eligible Days,
4) Issue No. 4 regarding Disproportionate Share Hospital Payment – SSI Fraction/Medicare Managed Care Part C Days,
5) Issue No. 5 regarding Disproportionate Share Hospital Payment – Medicaid Fraction/Managed Care Part C Days,
6) Issue No. 6 regarding Disproportionate Share Hospital Payment – Medicaid Eligible Labor Room Days,
7) Issue No. 7 regarding Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days,
8) Issue No. 8 regarding Disproportionate Share Hospital Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days,

9) Issue No. 9 regarding Outlier Payments – Fixed Loss Threshold,
10) Issue No. 10 regarding Rural Floor Budget Neutrality Adjustment,
11) Issue No. 11 regarding Medicare Crossover Bad Debts, and
12) Issue No. 12 regarding Medicare Charity Care Bad Debts.

The Provider has transferred Issue Nos. 2, 4, 5, 6, 7, 8, and 9 to group appeals. The Provider has withdrawn Issue Nos. 3, 10 and 12. The Medicare Contractor has filed jurisdictional challenges regarding the last two remaining issues in the appeal: Issue No. 1 - DSH/SSI % Provider Specific, and Issue No. 11 - Medicare Crossover Bad Debts.

Medicare Contractor's Contentions

The Medicare Contractor filed a jurisdictional challenged dated December 22, 2014 alleging that the Board does not have jurisdiction over the DSH SSI % Provider Specific issue. The Medicare Contractor states that the Provider does not meet the requirements of 42 U.S.C. § 1395oo(a)(1) in that the Provider has not shown it is dissatisfied with a final determination. The Medicare Contractor explains the Provider has not requested that its SSI be recalculated using its own fiscal year end as permitted by 42 C.F.R. 412.106(b)(3). Because the Provider has not made such a request/election, the Medicare Contractor has not made a final determination regarding this issue.

The Medicare Contractor also filed a jurisdictional challenge dated September 21, 2017, alleging that the Board does not have jurisdiction over the Crossover Bad Debts issue. The Medicare Contractor contends the Provider did not claim the Crossover Bad Debts it now seeks, and the Medicare Contractor did not adjust any of these claims the Provider now disputes. The Medicare Contractor claims that none of the adjustments cited by the Provider (Adjustment Numbers 1, 3, 5, 7, 14, 18, 20, 30, 31, 45, 49, and 50) render a final determination over the additional inpatient Crossover Bad Debts the Provider now disputes.[1] The Medicare Contractor also states that the Provider has a responsibility to identify its own Bad Debt claims on the cost report, and the Provider has not shown it was precluded from claiming these Bad Debts on its as-filed cost report.

The Provider's Contentions

The Provider filed a Jurisdictional Response dated January 19, 2015 addressing the challenge to the DSH SSI % Provider Specific issue. The Provider claims it is not asking for realignment of its fiscal year end in the SSI percentage, but is addressing the various errors of omission and commission that do not fit into Issue No. 2, the DSH SSI % Systemic Errors issue. The Provider claims it is dissatisfied with SSI percentage, and believes that it can identify patients believed to be entitled to both Medicare

[1] The Medicare Contractor acknowledges that it adjusted bad debts with Adj. No. 37. However, the Medicare Contractor states the adjusted bad debts are different than those the Provider now disputes. *See* Medicare Contractor's Jurisdictional Challenge (Sept. 21, 2017) at 2.

Part A and SSI who were not included in the SSI percentage determined by CMS. The Provider cites directly to *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) regarding this argument. The Provider concludes that because there was an adjustment to its DSH SSI percentage, the Board has jurisdiction over this issue.

The Provider filed a Jurisdictional Response dated October 17, 2017 addressing the challenge to the Crossover Bad Debts issue. The Provider asserts it is not required to claim these Bad Debts on the cost report, nor is it required to protest them, because the revised regulation with these requirements (42 C.F.R. § 405.1835(a)(1)) is "inconsistent with the plain language of the governing statute." [2] The Provider cites to *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988), arguing that once the Board has jurisdiction under 42 U.S.C. § 1395oo(a), it has the power to make revisions to other matters cover by that cost report pursuant to 42 U.S.C. § 1395oo(d), even though such matters may not have been considered by the Medicare contractor. The Provider also contends that the Secretary's reliance on the Must Bill Policy issued in Joint Signature Memorandum 370 (JSM-370) which requires providers to bill and receive a remittance from the State allows the Provider to appeal these self-disallowed costs under the Bethesda rationale.

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.

Issue No. 1 – DSH SSI Percentage (Provider Specific)

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

The Provider describes this issue in its appeal request as "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[3] The Provider claims the legal basis for this issue is "that the SSI percentage issue by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed."[4] The Provider also states it "is seeking 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."[5]

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[2] Provider's Jurisdictional Response (Oct. 17, 2017) at 1-2.
[3] *See* Model Form A – Individual Appeal Request (Nov. 12, 2013), Exhibit 3 at 1.
[4] *Id.*
[5] *Id.*

The Provider describes Issue No. 2 addressing DSH SSI Systemic Errors in its appeal request as "[w]hether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage."[6] The Provider states the legal basis for the issue is "the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the lead MAC to settle their Cost Report does not address all of the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F.Supp 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008)..."[7]

The Board finds that it has jurisdiction over the portion of Issue No. 1, the DSH SSI Percentage Provider Specific issue, which challenges the data used to calculate the SSI percentage as there was an adjustment to the SSI percentage (Adj. 49), 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[8] is duplicative of Issue No. 2, DSH SSI Systemic Errors, that was transferred to Case No. 13-2694G. The basis of both Issues is that the SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. Issue No. 1 challenging the accuracy of the SSI ratio data now resides in Case No. 13-2694G and it is therefore dismissed from this appeal.

Issue No. 2 – Crossover Bad Debts

The Board has *discretionary power* under 42 U.S.C. § 1395oo(d), after jurisdiction is established under 42 U.S.C. § 1395oo(a), to make a determination over all matters covered by the cost report. The Board can affirm, modify, or reverse a final determination of the Medicare contractor with respect to a cost report and make any other revisions on matters covered by the cost report even though such matters were not considered by the Medicare contractor in making its final determination.

The D.C. District Court recently upheld the Board's interpretation of the dissatisfaction requirement in § 1395oo(a) in *Saint Vincent Indianapolis Hospital v. Sebelius* 2015 WL 5728372 (D.D.C 2015) (hereinafter "*St. Vincent*"). In that case, the Board determined that the provider "failed to meet the jurisdiction prerequisite of being 'dissatisfied' with the amount of Medicare payment because the 'errors and omissions' alleged by the provider in its appeal stemmed from its own 'negligence' in understanding the Medicare regulations governing the reimbursement of such costs rather than the [Medicare Contractor's] action."[9] The Court found the Board's ruling is "based upon a permissible construction of the statute," and therefore affirmed the Board's dismissal.[10]

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[6] Model Form A – Individual Appeal Request (Nov. 12, 2013), Exhibit 3 at 1-2.
[7] *Id.*
[8] The Provider has stated it "is not seeking a SSI realignment" of the DSH calculation to its cost reporting period. *See* Provider's Jurisdictional Response (Jan. 19, 2015) at 2.
[9] *Id.* at 4 (citation omitted).
[10] *Id.*at 5.

In this instant case, the Provider concedes it failed to properly claim the Crossover Bad Debts it now seeks on its as-filed coast report, which it now attempts to correct. Only in hindsight did the Provider determine that it could (and should) have reported this item differently, thereby potentially increasing the amount of reimbursement. However, uncertainty as to the interpretation of a regulation does not necessarily make a claim for reimbursement futile. Rather, this case is precisely the situation described by the Supreme Court in *Bethesda* as being "on different ground" because the Provider "fail[ed] to request from the intermediary reimbursement for all costs to which [it was] entitled under applicable rules."[11]

Using the rationale in the *St. Vincent* case (which addresses the *Bethesda* case), the Board finds the errors and omissions for the Crossover Bad Debts raised in the appeal were due solely to the Provider's negligence in understanding the Medicare regulations governing the reimbursement of such items on the Medicare cost report. The Board also finds that only when the provider has established jurisdiction under § 1395oo(a) with respect to one or more of such claims/issues can the Board then exercise discretion to hear other claims not considered by the intermediary (*e.g.*, unclaimed costs).[12] While the Provider did file a jurisdictionally valid appeal for dissatisfaction with issues other than the Crossover Bad Debts issue that gives the Board jurisdiction under subsection (a), the Board declines to exercise discretion under 42 U.S.C. § 1395oo(d) to hear the appeal of this issue as it addresses items and services not claimed, or not properly claimed. Therefore, the Board dismisses the Crossover Bad Debts issue from the appeal.

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

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

[11] *Bethesda,* 485 U.S. 399 (1988) at 404-405.
[12] *See e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review,* CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.

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Refer to: 14-1124G

FEB 0 1 2018

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First Coast Service Options, Inc.
Geoff Pike
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
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RE: King & Spalding 2007 Low Income Pool Sec. 1115 Rehab DSH Waiver Days Group
Jurisdictional Challenge
PRRB Case Number: 14-1124G

Dear Mr. Polston and Mr. Pike,

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

Background:

The Board established a group appeal on December 2, 2013 for King & Spalding 2007 Low Income Pool Sec. 1115 Rehab 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]

The Medicare Contractor submitted a jurisdictional challenge on June 30, 2016 stating that the Rehab Provider Low Income Payment is not appealable. The Provider filed a responsive brief on July 15, 2016.

[1] Provider's appeal request at Tab 2 (November 27, 2013).

Medicare Contractor's Position – Rehab Low Income Payment – Not Appealable

The Medicare Contractor contends that in accordance with "Section 1886(j)(8)(B), there is no administrative or judicial review of the IRF prospective payments rates under paragraph (3)."[2] The Medicare Contractor maintains that, because the IRF rate is established by statute it is therefore a product of historical costs and adjustments to that federal rate. One of these adjustments to the rate is the Low income payment adjustment.[3] Accordingly, Section 1886(j)(8)(B) of the Medicare Act precludes administrative review of the IRF Low income payment adjustments, and thereby divests the Board of jurisdiction to hear this issue in the Provider's appeal. The Medicare Contractor asserts that the Board must comply with all of the provisions of the Medicare Act and the regulations issued thereunder.[4]

Provider's Position - Rehab Low Income Payment – Not Appealable

The Providers contend that the IRF Low income payment statute does not preclude review of the IRF DSH adjustment. The IRF PPS statute precludes review of IRF prospective payment rate described in § 1886(j)(3). Paragraph (3) of that section sets forth only the unadjusted IRF PPS payment rate.[5] The Providers argue that the Board previously held that paragraph (3) does not preclude review of the IRF DSH adjustment.[6] The Providers contend that it is not challenging the establishment of Low income payment but the Providers maintain that § 1886(j)(8) of the Medicare Act does not prohibit administrative or judicial review for certain aspects of the establishment of the IRF payments. The Providers also maintain there is no specific language within this act prohibiting administrative or judicial review as it pertains to the establishment of Low income payment.

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.

Inpatient Rehabilitation Facility Low-Income Payment

In reviewing the Medicare Contractor's allegations that 42 U.S.C. § 1395ww(j)(8)(B) unambiguously precludes administrative and judicial review of the IRF-PPS rates, the Board first looked to the statutory provision prohibiting certain judicial and administrative review. 42 U.S.C. § 1395ww(j)(8) specifies:

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[2] Medicare Contractor's Jurisdictional Challenge at ¶ I. (June 30, 2016)
[3] *Id* at ¶ II.
[4] 42 C.F.R. § 405.1867; *Id.*
[5] Providers' Response to Jurisdictional Challenge at 14. (July 15, 2016)
[6] *Id.*

> There shall be no administrative or judicial review . . . of the *establishment* of—
>
> (A) case mix groups, of the methodology for the classification of patients within such groups, and the appropriate weighting factors thereof under paragraph (2),
>
> (B) The prospective payment rates under paragraph (3),
>
> (C) Outlier and special payments under paragraph (4), and
>
> (D) Area wage adjustments under paragraph (6).[7]

The United States District Court for the District of Columbia in *Mercy Hosp., Inc. v. Burwell ("Mercy")*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016), recently concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's interpretation of the Low income payment ("LIP") adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The Board in *Mercy* had previously held that it had jurisdiction to review the Medicare Contractor's determination of the LIP adjustment.[8] The Administrator of CMS vacated the Board's decision concluding that the Board had lacked authority to hear the hospital's appeal in light of 42 U.S.C. § 1395ww(j)(8).[9] *Mercy* appealed to the United States District Court for the District of Columbia who affirmed the Administrator's decision.

The Board notes the text of § 1395ww(j)(8) prohibits administrative or judicial review of "*the establishment* of" the items listed in Subparagraphs (A) to (D). The Board finds the use of the word "establishment" in the statute significant.[10] The Providers are not challenging "the *establishment* of" either the federal rates or "the *establishment* of" the LIP adjustment to those rates, since this appeal challenges no part of the August 2001 Final Rule in which the Secretary established the LIP adjustment itself (*i.e.*, the formula used to calculate the adjustment). The Board finds no prohibition in 1395ww(j)(8) to administrative or judicial review of *"the calculation of"* the LIP adjustment where the focus is on the accuracy of the provider-specific data elements being used in the LIP adjustment calculation.

The United States District Court for the District of Columbia in *Mercy* when responding to *Mercy's* argument that if the limitation on review were as broad as the Secretary urges, then there would be nothing for inpatient rehabilitation providers to challenge.[11] The court stated:

> [b]ut the Secretary's interpretation does not leave inpatient rehabilitation providers with nothing to appeal. Suppose that a

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[7] Emphasis added.
[8] *Mercy Hospital v. First Coast Service Options, Inc.*, PRRB Dec. No. 2015-D7, 2013 WL 10381780, at *1 (Apr. 3, 2015).
[9] *Mercy Hospital v. First Coast Service Options, Inc.*, Review of PRRB Dec. 2015-D7, 2015 WL 3760091, at *11 (June 1, 2015).
[10] 42 U.S.C. § 1395ww(j)(8).
[11] *Mercy*, 2016 WL 4007072 at *7.

> contractor failed to account for a number of patients altogether, proposing reimbursement for 475 Medicare beneficiaries instead of the 600 Medicare beneficiaries that the provider believed it had treated. A challenge to the contractor's decision to exclude those 125 patients would ***not*** be a challenge to the prospective payment rates, and so would not be barred by paragraph (8)'s limitation on review. (Emphasis added).

Likewise, the Providers are not challenging the establishment of the prospective payment rates, but instead is challenging the accuracy of the Medicare Contractor's calculation of the provider-specific data elements being used in the LIP adjustment calculation. As articulated by the U.S. District Court, this is not a challenge to the prospective payment rates and as such would not be barred by paragraph (8)'s limitation on review.

The Board notes however, even in the absence of this exception articulated by the court which is applicable in the instant case, that it respectfully disagrees with the U.S. District Court for the District of Columbia's decision in *Mercy* which found that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the contractor's interpretation of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The Board has been clear on its decision in regards to this issue.[12] The Board continues to stand by its conclusion that it has jurisdiction to review the Medicare Contractor's determination of the LIP adjustment including the understatement of the LIP SSI ratio.

As noted above, the Administrator in *Mercy* and the U.S. District Court for the District of Columbia affirming the Administrator, reversed the Board's decision that it had jurisdiction over the LIP payment factors. The Administrator and the U.S. District Court restated the Medicare Contractor's assertion that administrative and judicial review of the LIP adjustment is precluded because § 1395ww(j)(8) precludes review of the prospective payment rate under paragraph (3) as well as *all* adjustments articulated in subsequent paragraphs. The Board, however, remains unconvinced, and continues to disagree with the Administrator and the U.S. District Court for the District of Columbia's overly broad interpretation.

Based on the above, the Board concludes that it has jurisdiction to hear the IRF low Income payment issue in 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 upon final disposition of this 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

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[12] See the Board's decision in *Mercy*; See also, the Board's latest decision in *St. Joseph Hospital of Eureka v. Noridian Healthcare Solutions*, PRRB Dec. No. 2016-D4, 2016 WL 10371515 (December 2, 2015).

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

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RE: King & Spalding 2008 Low Income Pool Sec. 1115 Rehab DSH Waiver Days Group
Jurisdictional Challenge
PRRB Case Number: 14-0682G

Dear Mr. Polston and Mr. Pike,

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

Background:

The Board established a group appeal on November 12, 2013 for King & Spalding 2008 Low Income Pool Sec. 1115 Rehab 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]

The Medicare Contractor submitted a jurisdictional challenge on June 30, 2016 stating that the Rehab Provider Low Income Payment is not appealable. The Provider filed a responsive brief on July 15, 2016.

[1] Provider's appeal request at Tab 2 (November 8, 2013).

Medicare Contractor's Position – Rehab Low Income Payment – Not Appealable

The Medicare Contractor contends that in accordance with "Section 1886(j)(8)(B), there is no administrative or judicial review of the IRF prospective payments rates under paragraph (3)."[2] The Medicare Contractor maintains that, because the IRF rate is established by statute it is therefore a product of historical costs and adjustments to that federal rate. One of these adjustments to the rate is the Low income payment adjustment.[3] Accordingly, Section 1886(j)(8)(B) of the Medicare Act precludes administrative review of the IRF Low income payment adjustments, and thereby divests the Board of jurisdiction to hear this issue in the Provider's appeal. The Medicare Contractor asserts that the Board must comply with all of the provisions of the Medicare Act and the regulations issued thereunder.[4]

Provider's Position - Rehab Low Income Payment – Not Appealable

The Providers contend that the IRF Low income payment statute does not preclude review of the IRF DSH adjustment. The IRF PPS statute precludes review of IRF prospective payment rate described in § 1886(j)(3). Paragraph (3) of that section sets forth only the unadjusted IRF PPS payment rate.[5] The Providers argue that the Board previously held that paragraph (3) does not preclude review of the IRF DSH adjustment.[6] The Providers contend that it is not challenging the establishment of Low income payment but the Providers maintain that § 1886(j)(8) of the Medicare Act does not prohibit administrative or judicial review for certain aspects of the establishment of the IRF payments. The Providers also maintain there is no specific language within this act prohibiting administrative or judicial review as it pertains to the establishment of Low income payment.

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.

Inpatient Rehabilitation Facility Low-Income Payment

In reviewing the Medicare Contractor's allegations that 42 U.S.C. § 1395ww(j)(8)(B) unambiguously precludes administrative and judicial review of the IRF-PPS rates, the Board first looked to the statutory provision prohibiting certain judicial and administrative review. 42 U.S.C. § 1395ww(j)(8) specifies:

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[2] Medicare Contractor's Jurisdictional Challenge at ¶ I. (June 30, 2016)
[3] *Id* at ¶ II.
[4] 42 C.F.R. § 405.1867; *Id.*
[5] Providers' Response to Jurisdictional Challenge at 14. (July 15, 2016)
[6] *Id.*

> There shall be no administrative or judicial review . . . of the *establishment* of—
>
> (A) case mix groups, of the methodology for the classification of patients within such groups, and the appropriate weighting factors thereof under paragraph (2),
>
> (B) The prospective payment rates under paragraph (3),
>
> (C) Outlier and special payments under paragraph (4), and
>
> (D) Area wage adjustments under paragraph (6).[7]

The United States District Court for the District of Columbia in *Mercy Hosp., Inc. v. Burwell ("Mercy")*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016), recently concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's interpretation of the Low income payment ("LIP") adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The Board in *Mercy* had previously held that it had jurisdiction to review the Medicare Contractor's determination of the LIP adjustment.[8] The Administrator of CMS vacated the Board's decision concluding that the Board had lacked authority to hear the hospital's appeal in light of 42 U.S.C. § 1395ww(j)(8).[9] *Mercy* appealed to the United States District Court for the District of Columbia who affirmed the Administrator's decision.

The Board notes the text of § 1395ww(j)(8) prohibits administrative or judicial review of "*the establishment* of" the items listed in Subparagraphs (A) to (D). The Board finds the use of the word "establishment" in the statute significant.[10] The Providers are not challenging "the *establishment* of" either the federal rates or "the *establishment* of" the LIP adjustment to those rates, since this appeal challenges no part of the August 2001 Final Rule in which the Secretary established the LIP adjustment itself (*i.e.*, the formula used to calculate the adjustment). The Board finds no prohibition in 1395ww(j)(8) to administrative or judicial review of *"the calculation of"* the LIP adjustment where the focus is on the accuracy of the provider-specific data elements being used in the LIP adjustment calculation.

The United States District Court for the District of Columbia in *Mercy* when responding to *Mercy's* argument that if the limitation on review were as broad as the Secretary urges, then there would be nothing for inpatient rehabilitation providers to challenge.[11] The court stated:

> [b]ut the Secretary's interpretation does not leave inpatient rehabilitation providers with nothing to appeal. Suppose that a

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[7] Emphasis added.
[8] *Mercy Hospital v. First Coast Service Options, Inc.*, PRRB Dec. No. 2015-D7, 2013 WL 10381780, at *1 (Apr. 3, 2015).
[9] *Mercy Hospital v. First Coast Service Options, Inc.*, Review of PRRB Dec. 2015-D7, 2015 WL 3760091, at *11 (June 1, 2015).
[10] 42 U.S.C. § 1395ww(j)(8).
[11] *Mercy*, 2016 WL 4007072 at *7.

> contractor failed to account for a number of patients altogether, proposing reimbursement for 475 Medicare beneficiaries instead of the 600 Medicare beneficiaries that the provider believed it had treated. A challenge to the contractor's decision to exclude those 125 patients would ***not*** be a challenge to the prospective payment rates, and so would not be barred by paragraph (8)'s limitation on review. (Emphasis added).

Likewise, the Providers are not challenging the establishment of the prospective payment rates, but instead is challenging the accuracy of the Medicare Contractor's calculation of the provider-specific data elements being used in the LIP adjustment calculation. As articulated by the U.S. District Court, this is not a challenge to the prospective payment rates and as such would not be barred by paragraph (8)'s limitation on review.

The Board notes however, even in the absence of this exception articulated by the court which is applicable in the instant case, that it respectfully disagrees with the U.S. District Court for the District of Columbia's decision in *Mercy* which found that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the contractor's interpretation of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The Board has been clear on its decision in regards to this issue.[12] The Board continues to stand by its conclusion that it has jurisdiction to review the Medicare Contractor's determination of the LIP adjustment including the understatement of the LIP SSI ratio.

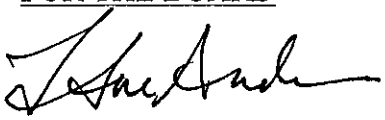
As noted above, the Administrator in *Mercy* and the U.S. District Court for the District of Columbia affirming the Administrator, reversed the Board's decision that it had jurisdiction over the LIP payment factors. The Administrator and the U.S. District Court restated the Medicare Contractor's assertion that administrative and judicial review of the LIP adjustment is precluded because § 1395ww(j)(8) precludes review of the prospective payment rate under paragraph (3) as well as *all* adjustments articulated in subsequent paragraphs. The Board, however, remains unconvinced, and continues to disagree with the Administrator and the U.S. District Court for the District of Columbia's overly broad interpretation.

Based on the above, the Board concludes that it has jurisdiction to hear the IRF low Income payment issue in 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 upon final disposition of this 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

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[12] See the Board's decision in *Mercy*; See also, the Board's latest decision in *St. Joseph Hospital of Eureka v. Noridian Healthcare Solutions*, PRRB Dec. No. 2016-D4, 2016 WL 10371515 (December 2, 2015).

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

cc: Federal Specialized Services
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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FEB 01 2018

Certified Mail

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Expedited Judicial Review Determination

RE: McKay 2013 SSI Part C Days Group, FYE 2013, PRRB Case No. 16-0146G
McKay 2013 Medicaid Fraction Part C Days Group, FYE 2013, PRRB Case No. 16-0147G

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 9, 2018 request for expedited judicial review (EJR) (received January 10, 2018) for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> Whether "enrollees in [Medicare] 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]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] "SSI" is the acronym for "Supplemental Security Income."
[2] "DSH" is the acronym for "disproportionate share hospital."
[3] Providers' January 9, 2018 EJR Request at 4.

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

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

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

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

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

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the

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[15] *Id.*

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

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

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

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

> 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* (*Allina I*),[22] vacated the FFY 2005 IPPS rule. However, the Secretary has not acquiesced to that decision.[23] More recently in *Allina Health Services v.* Price (*Allina II*),[24] 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.[25] In the May 2003 proposed rule for Federal fiscal year 2004, the Secretary proposed "to clarify" her long held position that "once a

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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] Providers' EJR request at 1.
[24] 2017 WL 3137976 (D.C. Cir. July 25, 2017).
[25] Providers' EJR Request at 4 citing to Allina 746 F.3d at 1105.

beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage."[26] Further, the Secretary went on, "[t]hese days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patients' days for a [Part C] beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[27] The Secretary explained that "once a beneficiary has elected to join a Medicare Advantage plan, that beneficiary's benefits are no longer administered under Part A."[28]

However, in the final rule for the Federal fiscal year 2005, the Secretary reversed course and adopted a policy to include Part C days in the Medicare Part A/SSI fraction and exclude the Part C days from the Medicaid fraction effective October 1, 2004.[29] The Secretary's actions were litigated in *Allina I* in which the Court concluded that the Secretary's final rule was not a logical outgrowth of the proposed rule and a vacatur was warranted.[30]

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.[31] 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.[32]

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2013. 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

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[26] 68 Fed Reg. at 27,208.
[27] *Id.*
[28] *Id.*
[29] 69 Fed Reg. 49,099 (Aug. 11, 2004).
[30] Providers' EJR Request at 5-6.
[31] *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.").
[32] *Id.*

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.[33]

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, and/or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[34] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request involves the 2013 fiscal year which began prior to October 1, 2013 (FFY 2014). Consequently, each of the Providers in the appeals utilizes a FFY 2013 SSI percentage, thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only Federal circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in Federal court in either the D.C. Circuit *or* the Federal circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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[33] *See* 42 C.F.R. § 405.1835 (2008).
[34] *See* 42 C.F.R. § 405.1837.

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

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

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

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen
Chairperson

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

cc: Pam VanArsdale, NGS (Certified Mail w/Schedules of Providers)
Wilson Leong, (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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FEB 02 2018

Certified Mail

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RE: **Expedited Judicial Review Determination**
15-2655G HRS 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group II
15-2654G HRS 2011 Medicaid Fraction Medicare Managed Care Part C Days Group II
15-2456G HRS 2010 DSH SSI Fraction Medicare Managed Care Part C Days Group II
14-3240G HRS 2011 Medicaid Fraction Medicare Managed Care Part C Days Group
14-3241G HRS 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group
14-1809G HRS 2010 DSH SSI Fraction Medicare Managed Care Part C Days Group
14-1810G HRS 2010 Medicaid Fraction Medicare Managed Care Part C Days Group
14-0367G HRS 2006 Medicaid Fraction Medicare Managed Care Part C Days Group

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 5, 2018 request for expedited judicial review (EJR) (received January 9, 2018) for the appeals referenced above. The Board's determination regarding jurisdiction and EJR is set forth below.

Issue in Dispute:

The issue in dispute in these cases is:

> Whether the Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSII 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. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).[1] [*Allina II*]

[1] Providers' January 5, 2018 EJR Request at 1.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services.

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

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

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

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[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 to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[17] 69 Fed. Reg. at 49,099.

> . . . *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.[18] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[20] vacated the FFY 2005 IPPS rule. However, the Secretary has not acquiesced to that decision.[21] More recently in *Allina Health Services v.* Price (*Allina II*),[22] 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 explain that because the Secretary has not acquiesced to the decision in *Allina,* the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from

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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] Providers' EJR request at 1.
[22] 2017 WL 3137976 (D.C. Cir. July 25, 2017).

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 Board is bound by the 2004 rule and the Providers and the Providers contend that the Board should grant their request for EJR.

The Providers assert that, pursuant to 42 U.S.C. § 1395oo(f)(1), the Board must grant EJR if it lacks the authority to decide a question of "law, regulation or CMS Ruling" raised by a provider.[23] The Providers maintain that the Board is bound by the regulation, there are not factual issues in dispute and the Board does not have the legal authority to decide the issue. Further, the Providers believe they have satisfied the jurisdictional requirements of the statute and the regulations.

Decision of the Board

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

Jurisdiction over Individual Participants

Case Nos. 14-1809G and 14-1810G: Provider # 13 Mount Nittany Medical Center (provider number 39-0268, FYE 6/30/2010)

In both cases 14-1809G and 14-1810G, under Tab D of the jurisdictional documents, the Provider #13, Mount Nittany Medical Center, included cost report Worksheet S-3, Part 1 and a statement that it had self-disallowed Medicare Managed Care Part C [days] from its as-filed cost report. The regulation, 42 C.F.R. § 405.1835(a)(1)(ii) (2008) requires that for cost reporting periods ending on or after December 31, 2008, providers self-disallow costs by following the applicable procedures for filing a cost report under protest. Board Rule 21.D, requires that providers which self-disallow items submit evidence of protest. Providers are to report the reimbursement effect of protested items on Worksheet E, Part A, Line 75 in accordance with CMS Pub. 15-2, §§ 15 and 4030.1. These manual provisions require that the provider specifically identify the disputed item(s) and supply a schedule showing the details and computations with its as-filed cost report.

In these cases, the Mount Nittany Medical Center did not furnish Worksheet E from the as-filed cost report and the accompanying list of protested amounts nor the audit adjustment report that demonstrates that the protested amount had been adjusted. The Board hereby dismisses Provider # 13, Mount Nittany Medical Center (provider number 39-0268, FYE June 30, 2010), from case

[23] *Id.* at 2. *See also* 42 C.F.R. § 405.1842 and PRRB Rule 42. The Board's Rules are found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/index.html.

numbers 14-1809G and 14-1810G because it did not demonstrate that it complied with the requirements of the regulation, 42 C.F.R. § 405.1835(a)(1)(ii) (2008).

Case Nos. 15-2654G and 15-2655G: Providers # 4 EMH Regional Medical Center (provider number 36-0145, FYE 12/31/2011) & # 5 Memorial Hospital (provider number 36-0156, FYE 9/30/2011)

On the Schedule of Providers in case numbers 15-2654G and 15-2655G, Provider # 4, EMH Regional Medical Center, identified adjustment 23 and S-D (self-disallowed) as the subject of the dispute. Adjustment 23 removed protested amounts from the cost report in the amount of $490,211. The Provider included Worksheets S-3, Part I and E, Part A from its settled cost reports with its jurisdictional documents. While there was a protested amount on the as-filed cost report as shown by adjustment 23, the Provider did not supply evidence of the specific items raised under protest, i.e., the schedule showing the details and computations that was to be filed with its as-filed cost report. Therefore, the Board cannot determine that Part C days issue in this appeal was claimed as a protested item. The Board hereby dismisses Provider # 4, EMH Regional Medical Center (provider number 36-0145, FYE December 31, 2011), from case numbers 15-2654G and 15-2655G because it has failed to demonstrate that it specifically protested Part C days when it filed its cost report as required by 42 C.F.R. § 405.1835(a)(1)(ii).

Provider # 5, Memorial Hospital, identified adjustment 25 as the subject of the appeal of its original NPR in both case numbers 15-2654G and 15-2655G. Adjustment 25 adjusted the allowable DSH percentage. There is no adjustment of the SSI percentage or a protested amount as the Board has required for appeals of the Part C Issue.[24] In addition, there was no other information furnished to further explain the adjustment. The Board hereby dismisses Provider #5, Memorial Hospital (provider number 36-0156, FYE September 30, 2011),from case numbers 15-2654G and 15-2655G because there is no evidence that the SSI percentage was adjusted or protested as required for Board jurisdiction under 42 C.F.R. § 405.1835(a)(1) (i) or (ii).

14-3240G and 14-3241G: Providers # 2 Sonoma Valley Hospital (provider number 05-0090, FYE 6/30/2011); # 11 Lima Memorial Hospital (provider number 36-0009, FYE 12/31/2011; # 15 Dallas Medical Center (provider number 45-0379, FYE 12/31/2011)

Provider # 2, Sonoma Valley Hospital, and Provider #11, Lima Memorial Hospital, which appealed from original NPRs, have adjustments to the SSI percentage, however, the SSI percentage was unchanged. The Providers did not identify an adjustment to the protested amount and indicate that they had protested the issue as required by 42 C.F.R. § 405.1835(a)(1)(ii) for Board jurisdiction. Since there is no change to the SSI percentage and the Providers did not protest the inclusion of Part C days in the Medicare fraction of the DSH adjustment, there is no basis for jurisdiction over the Providers appeals. The Board hereby dismisses Providers # 2, Sonoma Valley Hospital (provider number 05-0090, FYE June 30, 2011), and Provider # 11,

[24] The audit adjustment report provided does not show an adjustment to protested items at adjustment 24, rather, this adjustment is specifically labeled "HCAP Days."

Lima Memorial Hospital (provider number 36-0009, FYE December 31,2011), from case numbers 14-3240G and 14-3241G.

Provider # 15, Dallas Medical Center (provider number 45-0379, FYE December 31, 2011), appealed its October 20, 2014 revised NPR, but included an audit adjustment report page from its original Notice of Program Reimbursement (NPR) issued on March 18, 2014 (the revised NPR identifies the date of the original NPR). The Provider failed to establish that Part C days had been adjusted in the revised NPR as required by 42 C.F.R. § 405.1889(b) which states that only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal or the revised determination. Consequently, the Provider has not established that the Board has jurisdiction over the appeal and the Board hereby dismisses Provider # 15, Dallas Medical Center (provider number 45-0379, FYE December 31, 2011), from case numbers 14-3240G and 14-3241G.

Jurisdiction over the Remaining Provider Appeals

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

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

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

The Board has determined that remaining participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. The Providers which filed appeals from revised NPRs have adjustments to the SSI percentage, as required for jurisdiction. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group

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

appeal[28] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request involves the 2006, 2010 and 2011 fiscal years which began prior to October 1, 2013 (FFY 2014). Consequently, each of the Providers in the appeals utilizes a FFY 2013 SSI percentage, thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only Federal circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in Federal court in either the D.C. Circuit *or* the Federal circuit within which they are located. *See* 42 U.S.C. 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the providers' request for EJR for the issue and the subject years. The providers have 60

[28] *See* 42 C.F.R. § 405.1837.

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

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen
Chairperson

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

cc: Judith Cummings, CGS (Certified Mail w/Schedules of Providers)
Evaline Alcantara, Noridian Healthcare Solutions (Certified Mail w/Schedules of Providers)
Wilson Leong, (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

FEB 02 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: Bayfront Health Dade Center
Juris. Challenge DSH – SSI (Provider Specific)
PN: 10-0211
FYE: 09/30/2013
PRRB Case Number: 16-1574

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

Bayfront Health Dade Center ("Bayfront Health" or "Provider") filed a timely appeal on May 4, 2016 from its November 17, 2015 Notice of Program Reimbursement ("NPR"). The issues initially raised included:

(1) Disproportionate Share Hospital Payment ("DSH") – Supplemental Security Income ("SSI") (Provider Specific-Realignment)
(2) Disproportionate Share Hospital Payment ("DSH") – Supplemental Security Income ("SSI") (Systemic Error)
(3) DSH-Managed Care Part C Days-SSI Fraction
(4) DSH-Part A Dual Eligible Days-SSI Fraction
(5) DSH-Managed Care Part C Days-Medicaid Fraction
(6) DSH-Part A Dual Eligible Days-Medicaid Fraction
(7) DSH-Medicaid Eligible Days
(8) DSH-Managed Care Part C Days
(9) DSH-Part A Dual Eligible Days

After transfers of issues and abandonment of remaining SSI component of Issue #8 and #9 only Issue # 1 and 7 remain in the case.[1]

[1] *See* Medicare Contractor's Jurisdictional Challenge dated December 14, 2017 and Medicare Contractor Position dated November 22, 2017.

The Medicare Contractor filed a jurisdictional challenge on December 14, 2017 (received December 18, 2017) over Issue #1, DSH – SSI (Provider Specific). Bayfront Health filed their jurisdictional response on January 11, 2018.

Medicare Contractor's Position

The Medicare Contractor contends that the Board lacks jurisdiction over the SSI issue and further contends that the cost reporting period ended September 30, 2013, which coincides with the federal fiscal year, and thus renders the issue of SSI realignment moot. The Medicare Contractor also contends that the Provider Specific SSI inaccurate data portion issue is a duplicative issue. As the SSI data is the underlying issue in both Issue 1 and 2, and the Provider has transferred the duplicative issue to a group appeal.[2] Since the Board Rule 4.5 states a Provider may not appeal an issue from a final determination in more than one appeal the Medicare Contractor requests that the Board find that its lacks jurisdiction as the Provider is in violation of Board rule 4.5.[3]

Provider's Contentions

Bayfront Health contends that the Board has jurisdiction over the SSI Provider Specific issue, since the Medicare Contractor specifically adjusted the Providers SSI percentage and the Provider is dissatisfied with the amount of DSH payment it received for the cost report fiscal year of 2013. Bayfront Health further contends it has analyzed the Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS. The Provider believes that the SSI percentage determined by CMS is incorrect due to understated days in the SSI ratio. Bayfront Health contends it is addressing the various errors of omission and commission that do not fit into the "systematic errors" category and it is not seeking SSI realignment.[4]

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.

The Provider filed in its original appeal request, Issue #1 as "Whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation" with the contentions that the SSI percentage was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits so the SSI percentage issued by CMS is flawed. 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

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[2] Case # 16-0677GC.
[3] *See* Jurisdictional challenges dated December 14, 2017.
[4] See Providers Jurisdictional Response Dates January 10, 2018.

Bayfront Health filed its Final Position paper on October 30, 2017 briefing the SSI provider specific issue. The provider fails to mention the recalculation of the SSI% based on its cost reporting period in the paper, and states that when it receives data from CMS it will identify patients that were not included in the SSI percentage.[6]

The Board therefore finds that it lacks jurisdiction over the Provider Specific issue as it relates to realignment from the FFY to Cost Report Year, as the issue was abandoned by the Provider in its Final Position Paper. The Board also finds that the SSI-Realignment issue is moot as the Provider's Cost Reporting year end and the Federal Fiscal year are aligned. The Board finds that it has jurisdiction over the portion DSH-SSI (Provider) Specific issue as it relates to the "errors of omission and commission", there was an adjustment to the SSI percentage (Adj.18). However, the Board finds that this issue is duplicative of the SSI Systemic Errors issue appealed in Group Case No.16-0677GC as 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 remains open for the remaining issue of Medicaid Eligible Days.

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

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

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FEB 02 2018

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Nathan Summar
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Wisconsin Physicians Service
Byron Lamprecht
Cost Report Appeals
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Omaha, NE 68164

RE: Pasco Regional Medical Center
Juris. Challenge DSH – SSI (Provider Specific)
PN: 10-0211
FYE: 09/30/2008
PRRB Case Number: 13-1304

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

Pasco Regional Medical Center ("Pasco" or "Provider") filed a timely appeal on March 28, 2013 from its October 08, 2012 Notice of Program Reimbursement ("NPR"). The issues initially raised included:

(1) Disproportionate Share Hospital Payment ("DSH") – Supplemental Security Income ("SSI") (Provider Specific-Realignment)
(2) Disproportionate Share Hospital Payment ("DSH") – Supplemental Security Income ("SSI") (Systemic Error)
(3) DSH-Medicaid Eligible Days
(4) DSH-Managed Care Part C Days
(5) DSH-Medicaid Eligible Labor Room Days
(6) DSH-Part A Dual Eligible Days

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

The Medicare Contractor filed a jurisdictional challenge on July 8, 2013 over Issue #1, DSH – SSI (Provider Specific- realignment portion). The Medicare Contractor also filed an additional challenge on November 17, 2017 (received November 20, 2017) regarding the remaining portion of Issue #1, DSH – SSI (Provider Specific-Inaccurate data). Pasco filed their jurisdictional responses on July 24, 2013 and December 15, 2017.

[1] *See* Medicare Contractor's Jurisdictional Challenge dated November 17, 2017.

Medicare Contractor's Position

The Medicare Contractor contends that that the Board lacks jurisdiction over the SSI issue, since the Provider must make a formal request through its Medicare Contractor in order to realign the SSI percentage to the Provider's Fiscal Year and the Provider is not challenging that determination. The Medicare Contractor also contends that the Provider Specific SSI inaccurate data portion issue is a duplicative issue as the SSI data is the underlying issue in both Issue 1 and 2, and the Provider has transferred the duplicative issue to a group appeal.[2] Since the Board Rule 4.5 states a Provider may not appeal an issue from a final determination in more than one appeal the Medicare Contractor requests that the Board find that its lacks jurisdiction as the Provider is in violation of Board rule 4.5.[3]

Provider's Contentions

Pasco contends that the Board has jurisdiction over the SSI Provider Specific issue, since the Medicare Contractor specifically adjusted the Providers SSI percentage and the Provider is dissatisfied with the amount of DSH payment it received for the cost report fiscal year of 2008. Pasco further contends it has analyzed the Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS. The Provider believes that the SSI percentage determined by CMS is incorrect due to understated days in the SSI ratio. Pasco contends it is addressing the various errors of omission and commission that do not fit into the "systematic errors" category.[4]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare Contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the notice of the final determination.

The Provider filed in its original appeal request, Issue #1 as "Whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation" with the contentions that the SSI percentage was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits so the SSI percentage issued by CMS is flawed. 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."[5]

Pasco filed its Final Position paper on October 30, 2017 briefing the SSI provider specific issue. The provider fails to mention the recalculation of the SSI% based on its cost reporting period in the paper,

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[2] Case # 13-2327GC.
[3] *See* Jurisdictional challenges dated July 3, 2013 and November 17, 2017.
[4] *See* Provider's Jurisdictional Response dated December 14, 2017.
[5] *See* Providers Individual Appeal Request dated March 28, 2013.

and states that when it receives data from CMS it will identify patients that were not included in the SSI percentage.[6]

The Board therefore finds that it lacks jurisdiction over the Provider Specific issue as it relates to realignment from the FFY to Cost Report Year, the issue was abandoned by the Provider in its Final Position Paper. In addition, the Provider's cost report year is September 30, which is the same as the FFY, therefore no realignment would be needed. The Board also finds that it has jurisdiction over the portion of the 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.24).[7] However, the Board finds that this issue is duplicative of the SSI Systemic Errors issue appealed in Group Case No.13-2327GC as 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 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, 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.

[6] *See* Provider's Final Position Paper, page 9.
[7] *See* Provider's Jurisdictional Response, dated December 14, 2017, at 2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

FEB 02 2018

CERTIFIED MAIL

Amandeep Basra
Good Samaritan Hospital
901 Olive Drive
Bakersfield, CA 93308

RE: Good Samaritan Hospital (05-0257)
Quality Reporting Appeal for 2018
PRRB Case No. 18-0586

Dear Mr. Basara:

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

Pertinent Facts:

Good Samaritan Hospital was issued a Notice of Quality Reporting Program Noncompliance Decision for its 2018 Annual Payment Update (APU) on July 17, 2017.

The Provider filed an individual appeal with the Board on January 29, 2018. The appeal was dated January 19, 2018, but was not mailed until January 24, 2018 (according to the certified mail postmark.)

The appeal was not received by the Board until 196 days after the issuance of the final determination.

Board Determination:

Pursuant to 42 C.F.R. § 405.1835(a)(3), unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing. Pursuant to 42 C.F.R. § 405.1801(a) and PRRB Rule 21, for appeal requests filed after August 21, 2008, the date of filing is the date of receipt by the Board, or the date of delivery by a nationally-recognized next-day courier.

The Medicare Contractor issued the Provider's Notice of Quality Reporting Program Noncompliance Decision on July 17, 2017. The 185th day fell on Thursday, January 18th, 2017. The appeal was not filed with the Board until January 29th, 2017. This is 196 days after issuance of the final determination.

Because the appeal was not timely filed, the Board finds that it does not meet the regulatory filing requirements and hereby dismisses Case No. 18-0586.

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 F. Ziegler, CPA, CPC-A

For the Board:
Charlotte Benson for
L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Certified Mail

FEB 02 2018

Corinna Goron
Healthcare Reimbursement Services, Inc.
17101 Preston Road
Suite 220
Dallas, TX 75248

RE: **EJR Determination**

HRS 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days Group, PRRB Case No. 15-2457G
HRS 2013 SSI Fraction Medicare Managed Care Part C Days Group, PRRB Case No. 15-3344G
HRS 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days Group, PRRB Case No. 15-3342G

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 10, 2018 request for expedited judicial review (EJR)[1] (received January 12, 2018). The Board's decision with respect to jurisdiction and EJR is set forth below.

Issue in Dispute

The issue in dispute in these cases is:

> Whether dual eligible MA [Medicare Advantage] patients are "entitled to benefits under [Medicare] Part A." If the answer to the question is the affirmative, then these patient days should be included in both the numerator and the denominator of the Medicare fraction. On the other hand, if these patients are not entitled to benefits under Part A, the hospital days associated with these patients should be included in the Medicaid fraction.[2]

[1] The EJR request included appeals for case numbers 13-3619G and 14-0714G. In separate correspondence, the Board is seeking additional information need to process the EJR. This request for additional information stays the 30-day period to respond to the request for EJR. *See* 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii).
[2] *See generally* Providers' hearing request Tab 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").[3] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

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

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

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

[11] 42 C.F.R. § 412.106(b)(4).
[12] of Health and Human Services.

> including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[13]

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

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

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

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

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

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[13] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[14] *Id.*
[15] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[18] 69 Fed. Reg. at 49,099.

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I),*[21] vacated the FFY 2005 IPPS rule. However, the Secretary has not acquiesced to that decision.[22] More recently in *Allina Health Services v.* Price *(Allina II),*[23] 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 explain that because the Secretary has not acquiesced to the decision 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

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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] Providers' EJR request at 1.
[23] 2017 WL 3137976 (D.C. Cir. July 25, 2017).

(b)(2)(iii)(B) (the 2004 Rule). The Board is bound by the 2004 rule and the Providers and the Providers contend that the Board should grant their request for EJR.

The Providers assert that, pursuant to 42 U.S.C. § 1395oo(f)(1), the Board must grant EJR if it lacks the authority to decide a question of "law, regulation or CMS Ruling" raised by a provider. The Providers maintain that the Board is bound by the regulation, there are not factual issues in dispute and the Board does not have the legal authority to decide the issue. Further, the Providers believe they have satisfied the jurisdictional requirements of the statute and the regulations.

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 2010 and 2013.

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]

Case Numbers 15-3342G and 15-3344G

#10 Memorial Hospital (provider number 36-0156)

This Provider identified adjustment 17, protested amounts, as the subject of the appeal. The Provider did not include the schedule listing the individual protested amounts (in particular demonstrating the claim for Part C days) and that the amount claimed as a protested amount that ties to the amount of audit adjustment. This is required by 42 C.F.R. § 405.1835(a)(1)(ii) (the provider has preserved its right to appeal. . .by following the applicable procedures for filing a cost report under protest where the provider seeks payment that may not be allowable) and Board Rules[25] 6.3.C. and 21.D. The applicable rules for filing under protest require an entry on Line 75

[24] *See* 42 C.F.R. § 405.1835 (2008).
[25] The Board Rules can be found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.html.

of Worksheet E, Part A and Schedule showing the details and computation for this line. *See* Provider Reimbursement Manual (CMS Pub. 15-2) § 4030.1. Since the Provider did not demonstrate that it had protested the Part C days issue, the Board hereby dismisses Memorial Hospital (provider number 36-0156) from case numbers 15-3342G and 15-3344G.

The Board has determined that the remaining participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. Several of the Providers in case numbers 15-3342G and 15-3344G filed appeals from the failure of the Medicare contractor to issue final determination with 12 months after the receipt of a timely, perfected cost report. These Providers were not required to protest the Part C day issue.[26] In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[27] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request span fiscal years 2010 and 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 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;

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[26] *See* 42 C.F.R. § 405.1835(c)(2017).
[27] *See* 42 C.F.R. § 405.1837.

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

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

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

Board Members Participating:

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

FOR THE BOARD:

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

cc: Evaline Alcantara, Noridian Healthcare Solutions (Certified Mail w/Schedule of Providers)
Wilson Leong, FSS (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
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FEB 0 6 2018

CERTIFIED MAIL

Community Health Systems, Inc.
Nathan Summar
VP Revenue Management
4000 Meridian Boulevard
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Wisconsin Physicians Service
Byron Lamprecht
Cost Report Appeals
2525N 117th Avenue, Suite 200
Omaha, NE 68164

RE: Pasco Regional Medical Center
Juris. Challenge DSH – SSI (Provider Specific), Medicaid Eligible Days
PN: 10-0211
FYE: 09/30/2009
PRRB Case Number: 13-3351

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

Pasco Regional Medical Center ("Pasco" or "Provider") filed a timely appeal on August 29, 2013 from its March 4, 2013 Notice of Program Reimbursement ("NPR"). The issues initially raised included:

(1) Disproportionate Share Hospital Payment ("DSH") – Supplemental Security Income ("SSI") (Provider Specific-Realignment)
(2) Disproportionate Share Hospital Payment ("DSH") – Supplemental Security Income ("SSI") (Provider Specific-Realignment)
(3) DSH – SSI(Systemic Error)
(4) DSH-Medicaid Eligible Days
(5) DSH-Managed Care Part C Days
(6) DSH-Medicaid Eligible Labor Room Days
(7) DSH-Part A Dual Eligible Days

After transfers of issues and abandonment of the duplicative Issue # 2, (DSH –SSI Provider Specific issue) only Issue # 1 and 4 remain in the case.[1]

The Medicare Contractor filed a jurisdictional challenge April 22, 2014 over Issue #1, DSH – SSI (Provider Specific), realignment portion and then submitted and additional challenge on December 1,

[1] *See* Medicare Contractor's Jurisdictional Challenge dated December 1, 2017 and Medicare Contractor Position Paper dated November 13, 2017.

2017 (received December 4, 2017) regarding Issue #1, DSH – SSI (Provider Specific) inaccurate data and Issue #2 DSH-Medicaid Eligible Days.

Medicare Contractor's Position

Provider Specific SSI

The Medicare Contractor contends as in the Jurisdictional challenge filed on April 22, 2014 the Medicare Contractor continues to maintain that the Board lacks jurisdiction over the SSI issue and further contends that the cost reporting period ended September 30, 2009, which coincides with the federal fiscal year, and thus renders the issue of SSI realignment moot. The Medicare Contractor also contends that the Provider Specific SSI inaccurate data portion issue is a duplicative issue. Since the SSI data is the underlying issue in both Issue 1 and 3, and the Provider has transferred the duplicative issue to a group appeal.[2] Since the Board Rule 4.5 states a Provider may not appeal an issue from a final determination in more than one appeal. The Medicare Contractor requests that the Board find that its lacks jurisdiction as the Provider is in violation of Board rule 4.5.[3]

Medicaid Eligible Days

The Medicare Contractor contends the Board doesn't have jurisdiction over the additional Medicaid eligible days under 42 C.F.R. §405.1835, since the Medicare Contractor did not make an adjustment to disallow the disputed days. The Medicare Contractor contends the Provider included an amount in the protested line of the cost report[4], and the Medicare Contractor requested documentation from the Provider to support the nature of the protested amount reported on the as filed cost report. The Medicare Contractor states to date the Provider has not produced the requested information.[5]

Provider's Contentions

Provider Specific SSI

The Provider did not file a response to the Medicare Contractor's jurisdictional challenge, but argues in the Final Position Paper that based on certain data it received from the State of Florida they are able to identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS. Pasco claims they are seeking Medicare Part A data from CMS in order to reconcile its records with CMS data and upon completion of this review it will be entitled to a correction of these errors of omission to its SSI percentage.[6]

Medicaid Eligible Days

Pasco has not submitted a Jurisdictional response.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1840 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

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[2] Case # 13-2319GC.
[3] *See* Jurisdictional challenge dated December 1, 2017 (Received December 4, 2017).
[4] W/S E Part A line 30 is utilized.
[5] *See* Jurisdictional challenge dated December 1, 2017 (Received December 4, 2017).
[6] Providers Final Position Paper at 8-9.

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

Provider Specific SSI
The Provider filed in its original appeal request, Issues # 1 as "Whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation" with the contentions that the SSI percentage was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits so the SSI percentage issued by CMS is flawed. The Provider stated that it was seeking data from CMS in order to reconcile its records and identify the data that CMS failed to include. For issue #1, it went on to state that the Provider "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[7]

Pasco filed its Final Position paper on October 30, 2017 briefing the SSI provider specific issue. The provider fails to mention the recalculation of the SSI based on its cost reporting period in the paper, and states that when it receives data from CMS it will identify patients that were not included in the SSI percentage.[8]

The Board therefore finds that it lacks jurisdiction over the Provider Specific issue as it relates to realignment from the FFY to Cost Report Year. The issue was abandoned by the Provider in its Final Position Paper. In addition, the Provider's cost report year is September 30, which is the same as the FFY, therefore no realignment would be needed. The Board also finds that it has jurisdiction over the portion DSH-SSI (Provider) Specific issue as it relates to the "errors of omission and commission" as there was an adjustment to the SSI percentage (Adj.23). However, the Board finds that this issue is duplicative of the SSI Systemic Errors issue appealed in Group Case No. Case No. 13-2319GC as 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.

Medicaid Eligible Days
After reviewing Pasco's Individual Appeal Request and the Position Papers the Board finds that the Provider did not submit any supporting documentation that indicates that the Medicare Contractor made an adjustment to disallow the disputed days or that the days the Provider is making a claim for were filed under Protest on the Medicare Cost Report. The Medicare Contractor further identified three adjustments that impacted the Medicaid days reported by the Provider (Adjustment 19, 21, and 22). Adjustment 19, reconciled Medicaid days to the Medicaid logs. Adjustment 21, excluded non Medicaid days and pending days. Adjustment 22 reclassed labor and delivery days. The Provider has not documented that the days under appeal are in fact the days removed or adjusted by the Medicare Contractor as is required by 42 C.F.R. § 405.1835(a)(1), which provides, in relevant part:

> (a) A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by an intermediary or

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[7] See Providers Individual Appeal Request dated August 28, 2013.
[8] *See* Provider's Final Position Paper, page 9.

Secretary determination, only if --
(1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either –

(i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or

(ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).

Per Board Rule 7.2 C :

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

Although Pasco did include a protested amount on W/S E Part A, they did not document that claim included a request for additional Medicaid Eligible Days. Therefore, the Board finds that Pasco failed to claim the Medicaid eligible days or include them as a protested amount on the cost report. The Medicaid Eligible Days is dismissed as it does not meet the jurisdictional requirements of 42 C.F.R. § 405.1835(a)(1) and Board Rule 7.2(C).

As there are no issues remaining in this appeal the case will be closed. Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

FEB 0 6 2018

CERTIFIED MAIL

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

RE: Jurisdictional Decision
Provider: Cumberland County Hospital System
Case Number: 15-3165
FYE: 09/30/2011

Dear Mr. Ravindran and Ms. Polson:

Background

Cumberland County Hospital System, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. The Provider filed the request for appeal on August 10, 2015 regarding a Notice of Program Reimbursement dated February 11, 2015. There were eight issues stated in the Model Form A – Individual Appeal Request:

1) Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific),
2) Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI")(Systemic Errors)(hereinafter "DSH SSI Systemic Errors issue),
3) Disproportionate Share Hospital Payment – SSI Fraction/Medicare Managed Care Part C Days,
4) Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days),
5) Disproportionate Share Hospital Payment – Medicaid Eligible Days,
6) Disproportionate Share Hospital Payment – Medicaid Fraction/Medicare Managed Care Part C Days,
7) Disproportionate Share Hospital Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days), and
8) Outlier Payments – Fixed Loss Threshold.

The Provider has filed the following Requests to Transfer Issue to a Group Appeal:

1) Issue No. 2 to Case No. 15-3037G,
2) Issue No. 3 to Case No. 15-3032G,
3) Issue No. 4 to Case No. 15-3039G,
4) Issue No. 6 to Case No. 15-3038G,
5) Issue Nos. 7 to Case No. 15-3031G, and
6) Issue No. 8 to Case No. 15-3040G.

Issue Nos. 1 and 5 remain in the appeal. The Medicare Contractor has filed a jurisdictional challenge on January 11, 2018, regarding Issue No. 1 which addresses the Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific) issue (hereinafter "DSH SSI Percentage Provider Specific issue").

Medicare Contractor's Position

The Medicare Contractor's position is that Issue No. 1 addressing the DSH SSI Percentage Provider Specific is duplicative of Issue No. 2 addressing DSH SSI Systemic errors which now resides in Case No. 15-3037G. The Medicare Contractor claims the Provider is arguing the same issue in both this case and Case No. 15-3037G – that the DSH SSI Percentage is understated and the Provider needs the underlying data to determine what records were not included, if any, in the DSH calculation. The Medicare Contractor states the Provider is appealing the SSI Percentage data inaccuracy issue in more than one appeal which is prohibited by PRRB Rule 4.5.

The Provider's Position

Regarding Issue No. 1, the DSH SSI Percentage Provider Specific issue, the Provider contends that its' SSI percentage published by the Centers for Medicare & Medicaid Services was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the calculation.[1] The Provider states 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 determination of the SSI percentage.[2] The Provider also claims based upon CMS' admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) it is entitled to a correction of the errors of omission to its' SSI percentage.[3]

Regarding Issue No. 2, the DSH SSI Systemic Errors issue, the Provider alleges the SSI Percentage calculated by CMS and used by the Medicare Contractor is not correct, and does not address all of the

[1] Provider's Model Form A – Individual Appeal Request (Aug. 6, 2015), Tab 3 at 1.
[2] *Id.*
[3] Provider's Final Position Paper (Oct. 26, 2017) at 9.

deficiencies addressed in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008).[4] The Provider requested that this issue be transferred to Case No. 15-3037GC on March 16, 2016.[5]

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the 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. "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.

The Board finds it has jurisdiction over the portion of Issue No. 1 (DSH SSI Percentage Provider Specific) challenging the data used to calculate the SSI percentage as there was an adjustment to the DSH SSI percentage (Adj. 31), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the inaccurate data portion of Issue No. 1 is duplicative of Issue No. 2, the DSH SSI Systemic Errors issue. 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 the issue now resides in Case No. 15-3037G.

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 aspect of Issue No. 1, the DSH SSI Provider Specific issue, and it is dismissed from the appeal.

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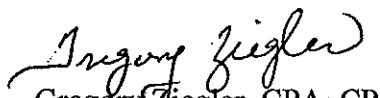
[4] Provider's Model Form A – Individual Appeal Request (Aug. 6, 2015), Tab 3 at 1-2.
[5] Provider's Model Form D – Request to Transfer an Issue to a Group Appeal (Mar. 14, 2016).
[6] 42 C.F.R. § 405.1835(a) (emphasis added).

This appeal remains open for resolution of Issue No. 5 - Medicaid Eligible Days. Review of this decision may be available under 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of this appeal.

Board Members

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

FOR THE BOARD



Gregory Ziegler, CPA, CPC-A
Boardmember

cc: Wilson Leong, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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FEB 08 2018

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First Coast Service Options, Inc.
Geoff Pike
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
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RE: King & Spalding 2008 Low Income Pool Sec. 1115 DSH Waiver Days Group
Jurisdictional Reconsideration/Reinstatement
PRRB Case Number: 14-0645G

Dear Mr. Polston and Mr. Pike,

The Provider Reimbursement Review Board ("Board") has reviewed the Jurisdictional Decision and Dismissal dated January 26, 2017 issued in the above-captioned appeal. On its own motion, the Board hereby reopens the case to reconsider its previous determination.

Background:

The Board established a group appeal on November 7, 2013 for King & Spalding 2008 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 a Section 1115 Medicare waiver program known as the Florida Low-Income Pool ("LIP") from the numerator of the Medicaid fraction of the Medicare DSH payment ... The Board further has jurisdiction over any adjustment to the Providers' Medicare DSH payment, including those aspects of the DSH calculation that were not specifically considered by the Intermediary in the NPR ..."[1]

All of the years in this appeal are 9/30/2008, prior to the requirement to file an "unclaimed cost" under protest. None of the providers documented that they included the Florida LIP 1115 Waiver days on their as-filed cost reports, or included them as a protested item. The Board previously found that Provider failed to make a claim for all the cost it was entitled to, and that the Provider was not barred from claiming the days by regulation or statute. In short, the Board previously found that the Provider simply failed to claim all the costs it was entitled to, and the Board therefore lacked jurisdiction over the 1115 Florida Low-Income Pool days for each Provider in 14-0645G under 42 U.S.C. § 1395oo(a).

[1] Provider's appeal request at Tab 2 (November 7, 2013).

Board's 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.

The Board finds, upon reconsideration, that each of the Providers included in Case No. 14-0645G have a right under 42 U.S.C. § 1395oo(a) to a hearing on the Florida Low Income Pool Sec. 1115 DSH waiver days. 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.*[2] The narrow facts of the *Bethesda* controversy dealt with the self-disallowed apportionment of malpractice insurance costs.[3] 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:

> [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.*[4]

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.[5]

The Board, upon reconsideration finds that had the Provider requested reimbursement from the Medicare Contractor for the Low-Income Pool 1115 Waiver days, the Medicare Contractor would not have provided it, and if fact, would have removed those days from the cost report as they did in many instances. The Medicare Contractor has argued throughout this appeal, that it's position, and the position of the Centers for Medicare and Medicaid Services, is that the days in dispute are not reimbursable under the DSH regulation, and therefore should be excluded from

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[2] *Bethesda,* 485 U.S. 399 (1988).
[3] *Id.* at 401-402.
[4] *Bethesda.* at 1258, 1259. (Emphasis added).
[5] *Id.* at 1259. (Emphasis added).

the cost report. The Board therefore concludes that they do in fact have jurisdiction over each provider in this appeal under Bethesda and reinstates each provider previously dismissed in PRRB appeal 14-0645G.

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

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

cc: Federal Specialized Services
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FEB 08 2018

Certified Mail

Lisa Ellis
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RE: *Essentia Health FFY 2016 Two Midnight Rule CIRP Group*
Palomar Pomerado Health FFY 2016 Two-Midnight Rule CIRP Group
St. Joseph Health System FFY 2016 Two-Midnight Rule CIRP Group
Susquehanna Health System FFY 2016 Two-Midnight Rule CIRP Group
Sutter Health FFY 2016 Two Midnight Rule CIRP
John Muir Health System FFY 2016 Two-Midnight Rule CIRP Group
Toyon FFY 2016 Two-Midnight Rule Group
PRRB Case Nos.: 16-1074GC, 16-1075GC, 16-1077GC, 16-1073GC, 16-1056GC, 16-1076GC and 16-1078G

Dear Ms. Ellis:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' October 27, 2017 Request for Expedited Judicial Review (EJR) (received October 30, 2017) and the Providers' January 12, 2018 Response to the Board's November 21, 2017 Request for Additional Information (received January 16, 2018), for the above-referenced appeals. The Board's decision is set forth below.

Issue under Dispute

Whether CMS' -0.2 percent payment adjustment related to the continuation of the Two Midnight Rule beginning October 1, 2015 (FFY 2016) is proper?[1]

Statutory and Regulatory Background

In the Final IPPS Rule for FFY 2014[2], the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) Rule[3] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

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[1] Providers' February 16, 2016 Group Appeal Request at Tab 3 (case numbers 16-1074GC, 16-1075GC, 16-1077GC, 16-1073GC, 16-1076GC, 16-1078G) and February 9, 2016 Group Appel Request at Tab 3 (case number 16-1056GC).
[2] 78 Fed. Reg. 50,496 (August 19, 2013).
[3] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).
[4] 78 Fed. Reg. at 50,907.

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because the Medicare review contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays, that may later be denied upon contractor review, by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[5]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one year from the date of service).[6]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[7] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24 hour or overnight period as a benchmark, i.e., patients who are expected to need care for 24 hours or overnight should be admitted. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, regardless of whether there is a later transfer or discharge resulting in no overnight patient stay. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[8]

In the FFY 2014 IPPS Proposed Rule,[9] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2 midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the

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[5] *Id.*
[6] *Id.*
[7] CMS Pub. 100-02, Chapter 6, § 20.6 and Chapter 1, § 10.
[8] 78 Fed. Reg. at 50,907-08.
[9] *See generally* 78 Fed. Reg. 27,486, 27,645-46 (May 10, 2013).

benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[10]

Medicare Part B

In the Final IPPS Rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, payments were made regardless of whether or not the subsequent hospital claims were within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[11]

As a result of the number of these administrative adjudications, the CMS Administrator issued Ruling CMS-1455-R[12] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "Medicare Program; Part B Billing in Hospitals." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[13] The 1 year deadline for filing claims remained unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[14]

The 2-Midnight Rule

In the Final IPPS Rule for FFY 2014, the Secretary pointed out that CMS had established policy that recognized there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS Rule included instructions that provided a benchmark to ensure that all

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[10] 78 Fed. Reg. at 50,908.
[11] *Id.*
[12] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/index.html.
[13] 78 Fed. Reg. at 50,909.
[14] *Id.* at 50,927.

beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[16] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[17]

The Secretary's actuaries estimated that the 2 midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters.

The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2 midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2 midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[18] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[19] In the Final IPPS Rules for 2015 and 2016, the Secretary did not reverse the 0.2 percent reduction

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[15] *Id.* at 50,944.
[16] *Id.*
[17] *Id.* at 50,945.
[18] *Id.* at 50,952-53.
[19] *Id.* at 50,990.

to the standardized amount made in 2014, and, therefore, continued to apply the contested reduction for the FFY 2015 and 2016 period.[20]

In the FFY 2017 Final IPPS Rule, the Secretary announced that she proposed to permanently remove the 0.2 percent reduction to IPPS and to provide a temporary one-time prospective increase to the FY 2017 of 0.6 percent in the standardized amount to retroactively correct for the 0.2 percent reductions in FYs 2014, 2015 and 2016.[21]

Providers' EJR Request

The Providers contend their appeal challenges the propriety of the Secretary's 0.2 percent payment adjustment related to the implementation of the Two Midnight Rule beginning October 1, 2013. The Providers maintain the rule narrows the definition of inpatient hospital services by requiring a longer expected inpatient stay at the time of admission. The Providers allege the Secretary wrongly estimated this new rule would result in a net increase in the number of covered inpatient hospital stays and arbitrarily implemented a 0.2 percent reduction to IPPS to offset the purported expected increase in covered inpatient hospital stays.[22] The Providers maintain they raised the issue based on the Federal Register, 80 Fed. Reg. 49325 dated August 17, 2015 (FFY 2016 Final Rule).[23]

The Providers contend that the Secretary's conclusion that the $220 million projected increase in IPPS payments as a result of the implementation of the Two Midnight rule is in error. The Providers maintain the Secretary's actuarial analysis that gave rise to the 0.2 percent reduction is unsupported and insufficiently calculated given the small fraction of inpatient and outpatient claims that were examined for the purposes of estimating the number of encounters that would shift between inpatient and outpatient, and vice versa. The Providers assert that the IPPS payment should have been adjusted upward, not downward to achieve budget neutrality. The Providers allege the Secretary did not provide a sufficient rational for the use of the exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i). The Providers dispute the contention that there is a widespread issue and justifies the use of an overall adjustment to IPPS rates. The Providers maintain the Secretary has not demonstrated that such an adjustment is authorized under the statutory authority referenced.

The Providers argue the Secretary's Two Midnight Rule should be set aside and the 0.2 percent reduction be reversed in order to correct and resolve this issue.[24] The Providers contend instead there should be an increase to the IPPS payments because the Providers believe the IPPS payments will decrease at a substantially higher rate than OPPS payments will increase, resulting in a net overall aggregate decrease in Medicare payments.[25] The Providers argue as the Board lacks the power to grant the relief sought, EJR should be granted pursuant to Section 1878(f)(1) of the Social Security Act (42 U.S.C. § 405.1842) and 42 C.F.R. § 405.1842.[26]

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[20] 79 Fed. Reg. 49,854, 50,011 (Aug. 22, 2014) and 80 Fed. Reg. 49,325, 49,593, 49,686 (Aug. 17, 2015).
[21] 81 Fed. Reg. 56762, 57059-60 (August 22, 2016).
[22] Providers' January 12, 2018 Response to the Board's Request for Additional Information at 1.
[23] *Id.* at 2.
[24] *Id.* at 1, 7.
[25] *Id.* at 7.
[26] *Id.* at 1.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the Requests for Hearing and Expedited Judicial Review. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). The documentation shows that the estimated amount in controversy for each group appeal exceeds $50,000, as required for a group appeal and the appeals were timely filed[27] from the issuance of the August 17, 2015 Federal Register (FFY 2016 Final Rule).[28] The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount in each case.

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;[29]

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

3) it is without the authority to decide the legal question of whether CMS 0.2 percent payment adjustment related to the continuation of the two midnight rule beginning October 1, 2015 is proper.

Accordingly, the Board finds that the above identified challenge to the FFY 2016 Two Midnight Rule falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' Request for Expedited Judicial Review for the issue and the subject year. The Providers have 60

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[27] The date of receipt by the Board was incorrectly noted on the Schedules of Providers for 7 of the 8 cases. The date of receipt for each appeal but 16-1056GC was February 16, 2016, which is 183 days after the Federal Register Publication. The Provider's appeal were timely filed within 180 days from the publication date, as the 180th day fell on a Saturday (February 13th), which moved the due date to the following Monday, which was a Federal Holiday (President's Day). Therefore the due date is moved to the next day the PRRB was open, which was Tuesday, February 16th. The appeal for 16-1056GC was received prior to the180th day on February 9, 2016.

[28] *See District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare and Medicaid Guide (CCH)* ¶ 41,025 (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

[29] Federal Specialized Services (FSS) filed jurisdictional challenges (received December 22, 2017) in case numbers 16-1075GC, 16-1076GC, and 16-1078G alleging that the Board lacks subject matter jurisdiction over these appeals because through its rulemaking and consistent with the *Shands Jacksonville Medical Center Inc., et al. v. Burwell*, 139 F. Supp. 3d 240 (2015) remand, CMS has established a correction applicable to the 2014 through 2016 FFYs. In the FFY 2017 Final Rule at 81 Fed. Reg. 56762, 57059-60 (August 22, 2016), the Secretary announced that she proposed to permanently remove the 0.2 percent reduction to IPPS and to provide a temporary one-time prospective increase to the FFY 2017 of 0.6 percent in the standardized amount to retroactively correct for the 0.2 percent reductions in FFYs 2014, 2015 and 2016. FSS argues this decision divest the Board of authority to consider relief in a FFY 2016 appeal. Thus, the appeals should be dismissed for lack of jurisdiction. However, the Providers' in these group appeals filed their appeals with the Board on February 16, 2016, before the temporary one time prospective increase to the FFY 2017 of 0.6 percent was effective. Thus, the Board may consider the relief requested in the FFY 2016 appeals. The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount in each case. Thus, the Board declines to dismiss the appeals for lack of jurisdiction.

days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these appeals, the Board hereby closes case numbers 16-1074GC, 16-1075GC, 16-1077GC, 16-1073GC, 16-1056GC, 16-1076GC and 16-1078G.

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

For the Board

L. Sue Andersen, Esq.
Chairperson

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

cc: Evaline Alcantara, Noridian Healthcare Solutions
Danene Hartley, National Government Services
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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FEB 08 2013

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Wilson C. Leong, Esq., CPA
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Re: CHS 2012 Low Volume Hospital Adjustment CIRP Group
Provider Nos.: Various
PRRB Case No.: 12-0026GC

Dear Mr. Hettich and Mr. Leong:

The Provider Reimbursement Review Board (Board) has reviewed the record in Case No. 12-0026GC, which is a fully formed group appeal. The issue before the Board is whether the Medicare Contractor's inclusion of Medicare Part C discharges when determining the providers' low volume hospital qualification and/or payment for fiscal year ("FY") 2012 was proper. This letter is to advise you that the Board has granted expedited judicial review ("EJR") on its own motion, and that the Board lacks the authority to decide the question in this case.

Factual Background and Parties' Arguments

In the August 18, 2011 Federal Register, the Secretary of the Department and Health and Human Services published the Final Rules for the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2012 Rates.[1] The Final Rule included the following provision regarding the payment adjustment for low volume hospitals:

> The [Medicare Contractor] will refer to the hospital's Medicare discharge data determined by CMS (for FY 2012 as shown in Table 14 of this final rule {which is listed in section VI. of the Addendum to this final rule and available via the Internet}), to determine whether or not the hospital meets the discharge criterion, and the amount of the payment adjustment, once it is determined that both the mileage and discharge criteria are met...[2]

The Providers in this CIRP group appeal allege that because Part C discharges were included in their discharge counts they did not qualify for a low volume adjustment payment, or they qualified for payments which were too low.[3] The Providers argue that the inclusion of Medicare Part C discharges in the calculation of FY 2012 low volume hospital adjustment qualification and payment is contrary to the plain language of the Low Volume Hospital Statute. The Providers also argue that the regulation at 42 C.F.R. § 412.101, which defines discharges as including Part C beneficiaries, is invalid and contrary to statute.[4]

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[1] 76 Fed. Reg. 51677 (Aug. 18, 2011).
[2] *Id.* at 51680.
[3] *See* Model Form B – Group Appeal Request (November 4, 2011) at Tab 2.
[4] *Id.*

On July 31, 2012, shortly after the appeal was filed, the Medicare Contractor requested that the Board exercise its own motion and grant EJR in this Case pursuant to 42 C.F.R. § 405.1842. The Medicare Contractor states that the Providers are challenging the regulation at 42 C.F.R. § 412.101. The Board issued an Own-Motion EJR Notice on December 7, 2016 requesting comments from the parties over the potential Own-Motion EJR as required by 42 C.F.R. § 405.1842(c). The Providers responded to the EJR Notice on January 6, 2017, stating that the Board has jurisdiction and that they agreed that EJR is appropriate.

Board Decision Regarding Jurisdiction and Own Motion Expedited Judicial Review

The Board has reviewed the Providers' requests for hearing and comments regarding EJR. 42 C.F.R. § 405.1842(a)(2) provides that EJR is appropriate where the Board finds that it has jurisdiction over the matter at issue, but that it does not have the authority to decide the legal question. The regulations also provide an opportunity for the Board to review the suitability of an appeal for EJR on its own motion, after making a finding that it has jurisdiction to conduct a hearing on a specific matter in accordance with 42 C.F.R. § 405.1840(a).[5]

Upon review of the Schedule of Providers, the Board finds that it does not have jurisdiction over two participants in the appeal. Among other requirements, a provider has a right to a Board hearing on a final Medicare Contractor determination if it is dissatisfied with the final determination, as set forth in the Contractor's written notice and it files its request within 180 days of that determination.[6] Participant #20 (Lea Regional Medical Center (Prov. No. 32-0065)) and Participant #38 (Tyler Memorial Hospital (Prov. No. 39-0192)) failed to include copies of their final determinations. Therefore, the Providers' have failed to document that they have timely filed an appeal from an appealable determination. Without a final determination approving or denying these Providers as low-volume hospitals, the Board cannot take jurisdiction. Therefore, the Board hereby dismisses Participant #20 and Participant #38 from this case. The Board finds that it has jurisdiction over the remaining Providers in the case.

The Providers in this case challenge the amendments to 42 C.F.R. § 412.101(a), which included Part C days in the low-volume hospital qualification determinations. The Board finds that this issue is a challenge to the substantive validity of a regulation, as identified in 42 C.F.R. § 405.1842, and it is bound by the regulation as published. Therefore, the Board finds that it lacks the authority to decide the specific legal question at issue, and that EJR is appropriate for the issue under appeal in this case.

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 Providers' assertions regarding 42 C.F.R. § 412.101(a), 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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[5] 42 C.F.R. § 405.1842(c).
[6] *See* 42 C.F.R. § 405.1835(a)(1).

4) it is without the authority to decide the legal question of whether 42 C.F.R. § 412.101(a), is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.101(a) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

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

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

Office of the Attorney Advisor

DEPARTMENT OF HEALTH & HUMAN SERVICES

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FEB 13 2018

Certified Mail

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RE: **Expedited Judicial Review Request**
Southwest Consulting Banner 2010 DSH SSI/Medicaid Part C Days Group, PRRB Case No. 15-0966GC
Southwest Consulting Banner 2011 DSH Medicaid Part C Days Group PRRB Case No. 15-1354GC
Southwest Consulting Banner 2008 DSH SSI/Medicaid Part C Days Group, PRRB Case No. 17-2225GC
Southwest Consulting Banner 2007 DSH SSI/Medicaid Part C Days Group, PRRB Case No. 18-0165GC
Southwest Consulting Banner 2009 DSH SSI/Medicaid Part C Days Group, PRRB Case No.18-0166GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 3, 2018 request for expedited judicial review (EJR) (received January 4, 2018)[1] and the additional information received on January 22, 2018 for the above-referenced appeals. The Board previously issued a letter dated January 12, 2018 requesting additional information which affected the 30-day time frame for responding to the EJR request. *See* 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii). The Board's determination is set forth below.

The issue in these appeals is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] Cases numbers 13-0220GC, 13-0706GC, 13-0904GC, 13-1641GC, 14-3503GC and 14-3939GC were included in the original EJR request. At the Group Representative's request, those cases were consolidated with the cases listed in the reference line of this letter and closed.
[2] January 3, 2018 EJR Request at 3.

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

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22] In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

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

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2007, 2008, 2009, 2010 and 2011.

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

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

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

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

the estimated amount in controversy exceeds $50,000, as required for a group appeal[27] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request span fiscal years 2007, 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

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

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

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[27] *See* 42 C.F.R. § 405.1837.

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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FEB 15 2018

PRRB Case No. 11-0517GC

CERTIFIED MAIL

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Byron Lamprecht
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Re: PRRB Case No. 11-0517GC
Expedited Judicial Review
Group: HCA FFY 2005 Outlier Threshold Group
FYE: 09/30/2005

Dear Mr. Roth and Mr. Lamprecht:

The Provider Reimbursement Review Board ("Board" or "PRRB") reviewed the Group's February 2, 2018 Replacement Request for EJR (Expedited Judicial Review). The Board determined that it has jurisdiction over all of the providers in the Group. The Board finds that the Outlier Threshold issue appealed by the Group is appropriate for EJR and hereby grants the Group's request. This EJR closes Case No. 11-0517GC. The Board's determination is outlined below.

Background

The common issue under appeal for the Group is CMS' determination of the outlier threshold.[1] The Group contends that the providers in this case qualified for and received payment for outliers when CMS incorrectly set the threshold too high.[2] The Group contends that the Secretary's failure to set the outlier threshold much lower was arbitrary and capricious.[3] The Group challenges the methodology (including data) that the Secretary used to calculate these outlier payments.[4] More specifically, the Group challenges the "outlier threshold" that the Secretary adopted in the FFY 2005 IPPS Final Rule (69 Fed. Reg. 48915, 49275-28 (Aug. 11, 2004)).[5]

[1] Group's Request to Reinstate Case Number 05-2082GC and to Reconfigure Calendar Year 12/31/05 to HCA FFY 2005 Outlier Threshold Group Appeal Letter ("Request to Reinstate") at 2, Feb. 16, 2011. Please note that several providers from Case No. 05-2082GC and 06-2155GC were transferred into Case No. 11-0517GC so that all FFY 2005 providers were consolidated.
[2] Request to Reinstate at 2.
[3] *Id.*
[4] Group's Replacement Request for EJR ("EJR Request") at 1, Feb. 2, 2018.
[5] EJR Request at 2.

42 U.S.C. § 1395ww(d)(5)(A) (emphasis added) provides:

> (ii) . . . [a] hospital may request additional payments in any case where charges, adjusted to cost, exceed . . . the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) *plus a fixed dollar amount determined by the Secretary*.
>
> (iii) The amount of such additional payment under clause[] . . . (ii) shall be determined by the Secretary and shall . . . approximate the marginal cost of care beyond the cutoff point applicable under clause . . . (ii).

The "fixed dollar amount" cited above represents the outlier threshold. The Group explains:

> By statute, the total outlier payments for a federal fiscal year can "not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year." 42 U.S.C. § 1395ww(d)(5)(A)(iv). The Secretary implements this requirement by setting the outlier threshold generally (and for FFY 2005) so that predicted outlier payments would equal 5.1% of predicted total DRG payments. *See* 69 Fed. Reg. at 49278. To pay for outliers, the Secretary is required to make a corresponding 5.1% cut to the national base payment rate (the "standardized amount") for each patient discharge. 42 U.S.C. § 1395ww(d)(3)(B). Thus, Congress requires the Secretary to design the annual outlier threshold so that the 5.1% cut in the standard DRG payments goes back to the hospitals in the form of outlier payments.[6]

The Group contends that, for FFY 2005, the Secretary's outlier methodology caused the outlier threshold to be set too high, which caused all of the outlier payments made during FFY 2005 to be too low.[7] Therefore, the Group argues, the Secretary failed to pay out the total amount of the outlier "pool" created by a reduction in standardized payments, and was otherwise unlawful.[8] The Group requests that the Board grant EJR for this issue.

Board Determination

The regulation governing EJR states:

> (a)(1) This section implements provisions in section 1878(f)(1) of the Act that give a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter (as described in § 405.1840 of this subpart), and the Board

[6] *Id.*
[7] *Id.* at 3.
[8] *Id.*

> determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
>
> . . .
>
> (f)(1) The Board's decision must grant EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines the following conditions are satisfied:
>
> (i) The Board has jurisdiction to conduct a hearing on the specific matter at issue . . .
>
> (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.[9]

Therefore, the Board must first determine jurisdiction before deciding whether it lacks the legal authority over the outlier threshold issue.

Jurisdiction

In order to have a right to a Board hearing, the providers in the group must be dissatisfied with their final determinations of the total amount of reimbursement due the providers; the amount in controversy must be at least $50,000; the date of receipt by the Board of the providers' hearing request must be no later than 180 days after the date of receipt of the providers' final determinations; and, the matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group.[10] The Schedule of Providers shows that each of the hospitals timely appealed.[11] The estimated reimbursement amount for the 300+ providers involved is $50,549,572.00.[12] Further, as the FYE is prior to the 12/31/08 amended regulation requiring providers to protest items not claimed on their cost reports, the holding in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) applies, allowing the providers to "self-disallow" the outlier fixed loss threshold, as they would not have an audit adjustment on their cost reports. Thus, with the exception of Cedars Medical Center (addressed below), the Board finds that it has jurisdiction over all of the providers pursuant to *Bethesda Hosp. Ass'n v. Bowen*.

Cedars Medical Center (Prov. 10-0009) appealed from a revised NPR (or final determination), which limits its appeal rights.[13] However, the Board finds that Cedars Medical

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[9] 42 C.F.R. § 405.1842.
[10] 42 C.F.R. § 405.1837.
[11] Schedule of Providers, Dec. 18. 2017.
[12] *Id.*
[13] *See* 42 C.F.R. § 405.1889 (2005).

Center had an adjustment to protested amounts (Audit Adjustment No. 23) with supplemental documentation showing an Outlier Threshold protested amount of $10,000.[14] The Board, therefore, finds that it has jurisdiction over Cedars Medical Center along with all of the providers in this case.

Legal Authority

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit EJR if the Board determines that it does not have the authority to decide a question of law, regulation, or CMS Ruling. In this case, the Group challenges the validity of the Secretary's outlier determination under 42 U.S.C. §§ 1395ww(d)(3)(B) and (d)(5)(A) (outlier statutes); 42 C.F.R. §§ 412.8(b), 412.80(c); and, 69 Fed. Reg. 48915, 49275-78 (Aug. 11, 2004). In the FFY 2006 IPPS Final Rule, the Secretary indicated that the 5-6% target for outlier payments was not met during FFY 2005, stating that the outlier payments were only 4.1% of total DRG payments in FFY 2005.[15]

The Group challenges the Secretary's application of the outlier methodology as arbitrary and capricious. Particularly, the Group notes that if the Secretary had properly modified the outlier projection methodology in accordance with comments that were made to the FFY 2005 IPPS Proposed Rule, (a) the threshold would have been lower and considerably more accurate and (b) the Providers would have received the additional outlier payments they were entitled to.[16] While the Secretary refused to follow the proposed modifications during FFY 2005, the Secretary did eventually agree that the methodology should be improved and adopted suggestions made during earlier rulemakings.[17] Such refusal to fix an imperfect process, the Group contends, is arbitrary and capricious, and thus, invalid.[18]

The Group states that the Board lacks the authority to set aside the outlier threshold or aspects of the outlier methodology because they were published in regulatory form by the Secretary.[19] The Group mentions that the Board issued EJR in an earlier, similar case (Case No. 11-0057GC) for FFY 2004.[20] Therefore, the Group believes EJR is appropriate and requests the Board to grant EJR. The Board agrees with the Group that it lacks legal authority in this case.

The Board finds that:

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[14] Schedule of Providers Tab 23D.
[15] EJR Request at 3 (citing 70 Fed. Reg. 47278, 47496 (Aug. 12, 2005)). The Group believes the calculation was even further below 4.1%.
[16] EJR Request 4-5.
[17] *Id.* at 3.
[18] *Id.* (citing to *Alvarado Cmty Hosp. v. Shalala*, 155 F.3d 1115 (9th Cir. 1998) and *Cnty of L.A. v. Shalala*, 192 F.3d 1005 (D.C. Cir. 1999) (holding that a refusal to discontinue an imperfect process is arbitrary and capricious)).
[19] EJR Request at 5.
[20] *Id.*

(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 Providers' assertions regarding 42 U.S.C. §§ 1395ww(d)(3)(B) and (d)(5)(A); 42 C.F.R. §§ 412.8(b), 412.80(c); and, 69 Fed. Reg. 48915, 49275-78 (Aug. 11, 2004), 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 the Secretary's fixed loss threshold for outlier payments is valid.

Accordingly, the Board finds that the outlier issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants EJR for the issue and subject year(s). The Group has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

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

FOR THE BOARD:

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

FEB 15 2013

CERTIFIED MAIL

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

RE: Jurisdictional Decision
Provider: Cape Fear Valley Medical Center
Case Number: 13-0269
FYE: 09/30/2007

Dear Mr. Ravindran and Ms. Polson:

Background

Cape Fear Valley Medical Center ("Provider") is appealing the amount of Medicare reimbursement determined by its Medicare Contractor in a Notice of Program Reimbursement ("NPR") dated October 2, 2012. The Provider filed a timely appeal from the NPR on December 27, 2012. The appeal request contained the following ten issues:

1) Issue No. 1 regarding Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific),

2) Issue No. 2 regarding Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI"),

3) Issue No. 3 regarding Disproportionate Share Hospital Payment – Medicaid Eligible Days,

4) Issue No. 4 regarding Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days,

5) Issue No. 5 regarding Disproportionate Share Hospital Payment – Medicaid Eligible Labor Room Days,

6) Issue No. 6 regarding Disproportionate Share Hospital Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days),

7) Issue No. 7 regarding Rural Floor Budget Neutrality Adjustment,

8) Issue No. 8 regarding Outlier Payments – Operating Cost to Charge Ratio and Outlier Reconciliation Adjustments,

9) Issue No. 9 regarding Medicare Crossover Bad Debts, and

10) Issue No. 10 regarding Medicare Charity Care Bad Debts.

The Provider has transferred Issue Nos. 2, 4, 5, 6, and 8 to group appeals. The Provider has withdrawn Issue Nos. 1, 3, 7 and 10. The Medicare Contractor has filed a jurisdictional challenge regarding the last remaining issue in the appeal: Issue No. 9 addressing Medicare Crossover Bad Debts.

Medicare Contractor's Position

The Medicare Contractor filed a jurisdictional challenge dated September 21, 2017, alleging that the Board does not have jurisdiction over the Crossover Bad Debts issue. The Medicare Contractor contends the Provider did not claim the Crossover Bad Debts it now seeks, and the Medicare Contractor did not adjust any of these claims the Provider now disputes. The Medicare Contractor states that none of the adjustments cited by the Provider (Adjustment Numbers 31, 37, 49, 64 and 65) render a final determination over the additional inpatient Crossover Bad Debts the Provider now disputes.[1] The Medicare Contractor also states that the Provider has a responsibility to identify its own Bad Debt claims on the cost report, and the Provider has not shown it was precluded from claiming these Bad Debts on its as-filed cost report.

The Provider's Position

The Provider filed a Jurisdictional Response dated October 17, 2017 addressing the challenge to the Crossover Bad Debts issue. The Provider asserts it is not required to claim these Bad Debts on the cost report, nor is it required to protest them, because the revised regulation with these requirements (42 C.F.R. § 405.1835(a)(1) is "inconsistent with the plain language of the governing statute."[2] The Provider cites to *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988), arguing that once the Board has jurisdiction under 42 U.S.C. § 1395oo(a), it has the power to make revisions to other matters cover by that cost report pursuant to 42 U.S.C. § 1395oo(d), even though such matters may not have been considered by the Medicare contractor. The Provider also contends that the Secretary's reliance on the Must Bill Policy issued in Joint Signature Memorandum 370 (JSM-370) which requires providers to bill and receive a remittance from the State allows the Provider to appeal these self-disallowed costs under the Bethesda rationale.

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[1] The Medicare Contractor acknowledges that it did adjust some Crossover Bad Debts, however, insists these are not the same accounts now in dispute. *See* Medicare Contractor's Jurisdictional Challenge (Sept. 21, 2017) at 2.
[2] Provider's Jurisdictional Response (Oct. 17, 2017) at 1-2.

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2012), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is (1) dissatisfied with the final determination of the intermediary, (2) the amount in controversy is $10,000 or more (or $50,000 for a group), and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board has *discretionary power* under 42 U.S.C. § 1395oo(d), after jurisdiction is established under 42 U.S.C. § 1395oo(a), to make a determination over all matters covered by the cost report. The Board can affirm, modify, or reverse a final determination of the Medicare contractor with respect to a cost report and make any other revisions on matters covered by the cost report even though such matters were not considered by the Medicare contractor in making its final determination.

The D.C. District Court recently upheld the Board's interpretation of the dissatisfaction requirement in § 1395oo(a) in *Saint Vincent Indianapolis Hosp. v. Sebelius,* 134 F. Supp. 3d 238 (2015) (hereinafter "*St. Vincent*"). In that case, the Board determined that the provider "failed to meet the jurisdiction prerequisite of being 'dissatisfied' with the amount of Medicare payment because the 'errors and omissions' alleged by the provider in its appeal stemmed from its own 'negligence' in understanding the Medicare regulations governing the reimbursement of such costs rather than the [Medicare Contractor's] action."[3] The Court found the Board's ruling is "based upon a permissible construction of the statute," and therefore affirmed the Board's dismissal.[4]

In this instant case, the Provider concedes it failed to properly claim the Crossover Bad Debts it now seeks on its as-filed coast report, which it now attempts to correct. Only in hindsight did the Provider determine that it could (and should) have reported this item differently, thereby potentially increasing the amount of reimbursement. However, uncertainty as to the interpretation of a regulation does not necessarily make a claim for reimbursement futile. Rather, this case is precisely the situation described by the Supreme Court in *Bethesda* as being "on different ground" because the Provider "fail[ed] to request from the intermediary reimbursement for all costs to which [it was] entitled under applicable rules."[5]

Using the rationale in the *St. Vincent* case (which addresses the *Bethesda* case), the Board finds the errors and omissions for the Crossover Bad Debts raised in the appeal were due solely to the Provider's negligence in understanding the Medicare regulations governing the reimbursement of such items on the Medicare cost report. The Board also finds that only when the provider has established jurisdiction under § 1395oo(a) with respect to one or more of such claims/issues can the Board then exercise

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[3] *Id.* at 4 (citation omitted).
[4] *Id.* at 5.
[5] *Bethesda,* 485 U.S. 399 (1988) at 404-405.

discretion to hear other claims not considered by the intermediary (*e.g.*, unclaimed costs).[6] While the Provider did file a jurisdictionally valid appeal for dissatisfaction with issues other than the Crossover Bad Debts issue that gives the Board jurisdiction under subsection (a), the Board declines to exercise discretion under 42 U.S.C. § 1395oo(d) to hear the appeal of this issue as it addresses items and services not claimed, or not properly claimed. Therefore, the Board dismisses the Crossover Bad Debts issue from the appeal, and the appeal is now closed as this was 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 H. Ziegler, CPA, CPC-A

FOR THE BOARD

Gregory H. Ziegler for

L. Sue Andersen, Esq.
Chairperson

cc: Wilson Leong, Esq., FSS

[6] *See e.g.*, *Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

FEB 16 2018

CERTIFIED MAIL

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

RE: Jurisdictional Decision
Provider: St. Mary's Hospital
Case Number: 13-1875
FYE: 09/30/2008

Dear Mr. Ravindran and Ms. VanArsdale:

Background

St. Mary's Hospital, or the Provider, is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in a Notice of Program Reimbursement ("NPR") dated October 22, 2012. The Provider filed a timely appeal from the NPR on April 19, 2013. The Model Form A – Individual Appeal Request (Apr. 18, 2013), Exhibit 3 lists the following seven issues:

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 ('DSH')/Supplemental Security Income ('SSI") (Sytemic Errors)" (hereinafter "DSH/SSI Systemic Errors");
3) Issue No. 3 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Days";
4) Issue No. 4 is entitled "Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days";
5) Issue No. 5 is entitled "Disproportionate Share Hospital Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)";

6) Issue No. 6 is entitled "Disproportionate Share – Exclusion of Part C Days from the Denominator of the Medicare Percentage; and
7) Issue No. 7 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Labor Room Days."

The Provider has requested transfers of Issue Nos. 2, 4, 5, 6 and 7 as follows:

1) Issue No. 2 to Case No. 13-2694G. *Model Form D – Request to Transfer Issue to Group Appeal (Dec. 9, 2013);*
2) Issue No. 4 to Case No. 13-2306G. *Model Form D – Request to Transfer Issue to Group Appeal (Dec. 9, 2013);*
3) Issue No. 5 to Case Nos. 13-2693G and 14-1171G (SSI Fraction). *Model Form D – Requests to Transfer Issue to Group Appeal (Dec. 9, 2013);*
4) Issue No. 6 to Case No. 14-1167G. *Model Form D – Request to Transfer Issue to Group Appeal (Dec. 9, 2013);* and
5) Issue No. 7 to Case No. 13-2697G. *Model Form D – Request to Transfer Issue to Group Appeal (Dec. 9, 2013).*

There are two issues remaining in the appeal: Issue No. 1 and Issue No. 3. Issue No 1 and transferred Issue No. 2 are relevant to this own motion jurisdictional review.

The Provider's Position

Issue No. 1 is stated in the appeal request as whether or not the Medicare Contractor used the correct SSI percentage in the DSH calculation, and alleges the DSH payment was not determined in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(i). The Issue states that the 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 claims 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 determination of the SSI percentage.[1]

[1] *See* Model Form A – Individual Appeal Request (Apr. 18, 2013), Exhibit 3 at 1.

Issue No. 2 is stated in the appeal request as whether or not the Secretary properly calculated the Provider's DSH SSI percentage. Part of the allegation in Issue No. 2 is that the SSI percentage calculated by CMS and used by the Medicare Contractor to settle the Provider's cost report does not address the deficiencies as described in the *Baystate*[2] case and it fails to encompass all SSI entitled individuals. The Provider states it is challenging the DSH calculation (SSI percentage) based on the following reasons:

1) Exhausted Benefit Days and Medicare Secondary Payor Days were improperly included in the DSH SSI Fraction,
2) Medicare Part C Days were improperly included in the DSH SSI Fraction, and
3) Revised/Improper Matching Methodology intended to comply with the *Baystate* case is deficient,
4) Failure to adhere to required notice and comment rulemaking procedures, and
5) CMS Ruling 1498R is invalid.[3]

Board Decision:

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

The Board finds regarding Issue No. 1., DSH SSI Percentage (Provider Specific), that it has jurisdiction over the issue which challenges the data used to calculate the SSI percentage as there was an adjustment to the SSI percentage (Adj. 20), 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, DSH SSI Systemic Errors, that was transferred to Case No. 13-2694G. The

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[2] *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[3] *See* Model Form A – Individual Appeal Request (Apr. 18, 2013), Exhibit 3 at 1-8.

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 Provider states it is seeking Medicare Provider and Analysis Review (MedPAR) data from CMS and that it is entitled to correction of SSI Percentage errors based upon the *Baystate* case in Issue No. 1,[4] which is the same stated issue in Issue No. 2. Issue No. 1, DSH SSI Percentage (Provider Specific) is therefore dismissed from the appeal as it is duplicative, and the issue resides in Case No. 13-2694G.

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

Board Members

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
Board Member

cc: Wilson Leong, Esq., FSS

[4] Provider's Final Position Paper (Oct. 30, 2017) at 8-9.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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18-0243

Certified Mail

FEB 21 2018

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

Re: Sutter Auburn Faith Hospital, Provider No. 05-0498, FYE 12/31/05, Case No. 18-0243

Dear Mr. Jaeger:

The Provider Reimbursement Review Board ("Board") is in receipt of the above-captioned appeal. The background of the case and the Board's decision are set forth below.

BACKGROUND:

On November 16, 2017, the Board received the Provider's appeal, based on a revised Notice of Amount of Corrected Program Reimbursement dated May 11, 2017. On November 22, 2017, the Board established the case and issued an Acknowledgement and Critical Due Dates notice.

DECISION OF THE BOARD:

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.

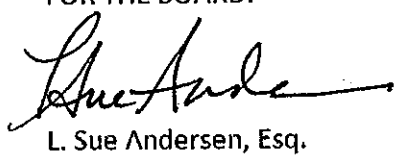
Pursuant to 42 C.F.R. §405.1801(a)(1)(iii), the date of receipt of a final determination is presumed to be five (5) days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually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

The final determination appealed by the Provider was issued on May 11, 2017. The Provider's appeal was due to the Board, including the five (5) day presumption, on Sunday, November 12, 2017. The due date would then be moved to the next business day, November 13, 2017. As the Provider's appeal was not received until November 16, 2017, it did not meet the timeliness requirement. Therefore, the Board dismisses the appeal.

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

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

FOR THE BOARD:



L. Sue Andersen, Esq.
Chairman

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

CC: Noridian Healthcare Solutions
Evaline Alcantara
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15-3160 **CERTIFIED MAIL** FEB 21 2018

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RE: Jurisdictional Determination
The Hospital of Central Connecticut
Provider No.: 07-0035
FYEs: September 30, 2012
PRRB Case Nos.: 15-3160

Dear Mr. Ravindran and Ms. VanArsdale:

This case involves The Hospital of Central Connecticut's ("Central Connecticut") appeal of its Medicare reimbursement for the fiscal year ending ("FYE") on September 30, 2012. The Provider Reimbursement Review Board ("PRRB" or "Board") has, by its own motion, reviewed Central Connecticut's jurisdictional documentation.[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear Central Connecticut's appeal of its Supplemental Security Income ("SSI") percentage "provider-specific" issue, as this issue is already contained within a group appeal, or its Medicaid eligible days issue, because Central Connecticut did not claim or protest these days on its cost report, as required by the applicable regulations. As these two issues are the only issues involved in Central Connecticut's above-referenced appeal, the Board hereby closes this case, as explained below.

Pertinent Facts

On August 10, 2015, the Board received Central Connecticut's request for a hearing ("RFH") regarding its February 25, 2015 Notice of Program Reimbursement ("NPR"). In its RFH, Central Connecticut seeks Board review of ten issues. Shortly after filing its RFH, Central Connecticut transferred eight 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 the instant appeal.

[1] Following the Board's own motion jurisdictional review, the Board received a February 8, 2017 jurisdictional challenge filed by the Medicare Contractor's representative, Federal Specialized Services.

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 C.F.R. §§ 405.1835-405.1840 (2015), 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) (2015), 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.

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 its RFH, Central Connecticut summarizes its SSI "provider-specific" issue in the following manner:

> The Provider contends that its[] SSI percentage published by the Centers for Medicare [&] Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]. . . The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[2]

With respect to its SSI "systemic" issue, Central Connecticut describes the issue as follows:

> The Provider[] challenge[s] [its] SSI percentage[] based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days[,] and
> 6. Failure to adhere to required notice and comment rule making procedures.[3]

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[2] RFH TAB 3, at unnumbered page 1.
[3] RFH TAB 3, at unnumbered pages 1-2.

In its SSI "systemic" issue statement, Central Connecticut sets out a long list of reasons why it claims that CMS incorrectly computed its SSI percentage. In its SSI "provider-specific" issue statement, Central Connecticut 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 Central Connecticut'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 Central Connecticut's SSI "provider-specific" issue statement includes a proclamation that Central Connecticut "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.[4] The Board also notes that Central Connecticut's cost reporting period is the *same* as the federal fiscal year underlying the SSI percentage calculation.[5]

As Central Connecticut previously transferred its SSI "systemic" issue into a group appeal, PRRB Case No. 15-1416G, the Board hereby dismisses, pursuant to Board Rule 4.5, Central Connecticut's duplicative SSI "provider-specific" issue from the instant appeal.

Issue 2—Medicaid eligible days

Under the applicable Board jurisdictional regulations, Central Connecticut must demonstrate dissatisfaction with the amount of Medicare payment with respect to its Medicaid eligible days by either including a claim for the days on the disputed cost report or by self-disallowing the days by filing the cost report under protest.[6] In the instant appeal, Central Connecticut lists Audit Adjustment Number 16 as the adjustment that pertains to its Medicaid eligible days issue,[7] but Adjustment 16 is an adjustment to the SSI percentage/fraction and disproportionate share hospital ("DSH") payment calculation, not an adjustment to the Medicaid fraction.[8]

Within its final position paper ("FPP"), Central Connecticut argues that "the total number of [Medicaid Eligible] days reflected in its[] 2012 cost report does not reflect an accurate number of Medicaid eligible days . . ."[9] The Medicare Contractor states, however, that, 14 months following the end of the disputed fiscal year, it offered Central Connecticut the opportunity to "revisit the cost report filing prior to the beginning of [the Medicare Contractor's] review."[10] The Medicare Contractor states that Central Connecticut filed an amended cost report that the

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[4] *See* 42 C.F.R. § 412.106(b)(3) (2015).
[5] For the 2012 cost reporting period, both the federal fiscal year and Central Connecticut's fiscal year end on September 30, 2012.
[6] 42 C.F.R. § 405.1835(a)(1) (2015).
[7] RFH TAB 3, at unnumbered page 6.
[8] RFH TAB 4.
[9] Central Connecticut FPP at 8.
[10] Medicare Contractor FPP Ex. at 16.

Contractor accepted on April 29, 2014.[11] Central Connecticut included approximately 16,200+ Medicare paid and HMO/eligible days on its amended cost report and the Medicare Contractor reports that it "made no changes to the Medicaid Paid or Medicaid HMO/eligible Days [*sic*] from the amended cost report to the finalized cost report."[12]

Central Connecticut has not demonstrated that it protested additional Medicaid eligible days on its cost report and the Medicare Contractor did not adjust Central Connecticut's Medicaid eligible days on either the as-filed or amended cost reports. The Board, therefore, finds that Central Connecticut is unable to demonstrate dissatisfaction with the amount of Medicare payment for Medicaid eligible days, as set out under the regulations.[13] Thus, the Board concludes that it does not have jurisdiction to hear Central Connecticut's Medicaid eligible days and dismisses this issue from the instant appeal.

Conclusion

The Board finds as follows:

(1) Central Connecticut's SSI "provider-specific" issue and its SSI "systemic" issue are the same issue. Since Central Connecticut transferred its SSI "systemic" issue to a group appeal and, pursuant to Board Rule 4.5, a provider may not appeal an issue from a final determination in more than one appeal, the Board hereby dismisses Central Connecticut's SSI "provider-specific" issue from the instant appeal;
(2) The Board lacks jurisdiction to hear Central Connecticut's appeal of its Medicaid eligible days issue, thus this issue is hereby dismissed from the instant appeal; and
(3) As PRRB Case No. 15-3160 contains no additional issues, the Board hereby closes this case.

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

Board Members Participating:

L. Sue Andersen, Esq.
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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: Joe Bauers, Federal Specialized Services
Wilson Leong, Federal Specialized Services

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[11] Medicare Contractor FPP Ex. at 16.
[12] *Id.* at 16-17.
[13] *See* 42 C.F.R. § 405.1835(a)(1) (2015).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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FEB 21 2018

Certified Mail

Christopher L. Keough
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RE: Expedited Judicial Review Request
07-2352GC Legacy Health Services 2005 DSH Medicare Part C Dual Eligible CIRP Group
13-0092GC Legacy Health 2008 DSH Medicare Part C Days CIRP Group
13-1527GC Legacy Health 2009 DSH SSI Fraction Denominator Part C Days Group
13-1532GC Legacy Health 2009 DSH Medicaid Fraction Part C Days Group
13-3581GC Legacy Health 2010 DSH SSI Denominator Part C Days CIRP Group
13-3594GC Legacy Health 2010 DSH Medicaid Part C Days CIRP Group
14-1853GC Legacy Health 2011 DSH SSI Denominator Part C Days CIRP Group
14-1854GC Legacy Health 2011 DSH Medicaid Fraction Part C Days CIRP Group
14-3161GC Legacy Health 2012 DSH SSI Fraction Part C Days Group
14-3163GC Legacy Health 2012 DSH Medicaid Fraction Part C Days Group
15-1380GC Legacy Health 2013 DSH SSI Fraction Part C Days Group
15-1381GC Legacy Health 2013 DSH Medicaid Fraction Part C Days Group
16-1033GC Legacy Health 2014 DSH SSI Fraction Part C Days Group
16-1035GC Legacy Health 2014 DSH Pre-10/1/2013 Medicaid Fraction Part C Days Group

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 25, 2018 request for expedited judicial review (EJR) (received January 26, 2018) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these appeals is:

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

[1] January 25, 2018 EJR Request at 4.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services

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

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

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

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[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 to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[17] 69 Fed. Reg. at 49,099.

> . . . *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.[18] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.[21]

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed

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

course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

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

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

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2005, 2008, 2009, 2010, 2011, 2012, 2013 and 2014.

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

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[22] 69 Fed. Reg. at 49,099.
[23] *Allina* at 1109.
[24] 108 S.Ct. 1255 (1988).
[25] *See* 42 C.F.R. § 405.1835 (2008).

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[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 2005, 2008, 2009, 2010, 2011, 2012, 2013 and 2014, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request. [27]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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[26] *See* 42 C.F.R. § 405.1837.

[27] On August 3, 2017, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in a number of cases identified in the EJR request. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina.* The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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

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

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: John Bloom, Noridian (Certified Mail w/Schedules of Providers)
Wilson Leong, (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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FEB 22 2018

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RE: CMC FFY 2018 ATRA/MACRA 0.7% IPPS Payment Reduction Group
FFY 2018
PRRB Case No. 18-0558GC

Dear Ms. Pagonis:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 24, 2018 request for expedited judicial review (EJR) (received January 25, 2018). The decision of the Board is set forth below.

Issue in Dispute

The Providers are challenging:

> [T]he Centers for Medicare & Medicaid Services' ("CMS" [sic]) failure to restore a 0.7% reduction to Medicare Inpatient Prospective Payment System ("IPPS") rates for inpatient discharges at all IPPS hospitals, including [the hospitals in this group appeal] occurring on or after October 1, 2017, which affects the Providers' for their fiscal years ("FYs" 2017, 2018 and/or 2019).[1]

Statutory and Regulatory Background

In the Federal year (FY) 2008 inpatient prospective payment system (IPPS) final rule[2], the Secretary[3] adopted the Medicare severity diagnosis-related group (MS–DRG) patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. This Secretary believes that by increasing the number of MS–DRGs and more fully taking into

[1] Providers' January 25, 2018 EJR Request at 1.
[2] 72 FR 47,130, 47140 through 47189 (Aug. 22, 2007)
[3] of the Department of Health and Human Services.

account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs encourage hospitals to improve their documentation and coding of patient diagnoses.[4]

In the FY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FY 2008, -1.8 percent for FY 2009, and -1.8 percent for FY 2010.[5]

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 (Public Law 110–90) (TMA). Section 7(a) of this statute reduced the documentation and coding adjustment made as a result of the MS–DRG system that the Secretary adopted in the FY 2008 IPPS final rule to -0.6 percent for FY 2008 and -0.9 percent for FY 2009.[6]

The Secretary implemented a series of adjustments required under sections 7(b)(1)(A) and 7(b)(1)(B) of the TMA, based on a retrospective review of FY 2008 and FY 2009 claims data. The Secretary completed these adjustments in FY 2013, but indicated in the FY 2013 IPPS/LTCH [Long Term Care Hospital] PPS final rule that delaying full implementation of the adjustment required under section 7(b)(1)(A) of the TMA until FY 2013 resulted in payments in FY 2010 through FY 2012 being overstated, and that these overpayments could not be recovered.[7]

Section 631 of the American Tax Payer Relief Act of 2012 (ATRA) amended section 7(b)(1)(B) of the TMA to require the Secretary to make a recoupment adjustment or adjustments totaling $11 billion by FY 2017. This adjustment represented the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under section 7(b)(1)(A) of the TMA until FY 2013. As discussed above, this delay in implementation resulted in overstated payment rates in FYs 2010, 2011, and 2012. The resulting overpayments could not have been recovered under the TMA.

The adjustment required under section 631 of the ATRA was a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, the Secretary anticipated that any adjustment made to reduce payment rates in one year would eventually be offset by a

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[4] 81 Fed. Reg. 56,762, 56,780 (Aug. 22, 2016).
[5] 82 Fed. Reg. 37,990, 38,008 (Aug. 17, 2017).
[6] *Id.*
[7] 82 Fed. Reg. at 38,008.

positive adjustment in 2018, once the necessary amount of overpayment was recovered. However, section 414 of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, Public Law 114–10, replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. However, section 15005 of the 21st Century Cures Act (Pub. L. 114–255), reduced the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points. [8]

The Secretary's actuaries estimated that a -9.3 percentage point adjustment to the standardized amount would be necessary if the Secretary was to fully recover the $11 billion recoupment required by section 631 of the ATRA in FY 2014. It is often the Secretary's practice to phase in payment rate adjustments over more than one year, in order to moderate the effect on payment rates in any one year. Therefore, consistent with the policies that the Secretary adopted in many similar cases, the Secretary implemented a -0.8 percentage point recoupment adjustment to the standardized amount in FY 2014. The Secretary estimated that if adjustments of approximately -0.8 percentage point were implemented in FYs 2014, 2015, 2016, and 2017, using standard inflation factors, the entire $11billion would be accounted for by the end of the statutory 4-year timeline.[9]

Consistent with the approach discussed in the FY 2014 rulemaking for recouping the $11 billion required by section 631 of the ATRA, in the FY 2015 IPPS/LTCH PPS final rule[10] and the FY 2016 IPPS/LTCH PPS final rule,[11] the Secretary implemented additional -0.8 percentage point recoupment adjustments to the standardized amount in FY 2015 and FY 2016, respectively. The estimated that these adjustments, combined with leaving the prior -0.8 percentage point adjustments in place, would recover up to $2 billion in FY 2015 and another $3 billion in FY 2016. When combined with the approximately $1 billion adjustment made in FY 2014, the Secretary estimated that approximately $5 to $6 billion would be left to recover under section 631 of the ATRA by the end of FY 2016.

In the FY 2017 IPPS/LTCH PPS proposed rule,[12] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under section 631 of the ATRA. For the FY 2017 IPPS/LTCH PPS final rule,[13] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FY 2014 through FY 2017 without exceeding this amount is -1.5 percentage points. Based on those updated estimates by the Office of the Actuary using the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under section 631 of the ATRA.[14]

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[8] *Id.*
[9] *Id.*
[10] 79 Fed. Reg. 49,326, 49,874 (Aug. 24, 2014).
[11] 80 Fed. Reg. 49,326, 49345 (Aug. 17, 2015).
[12] 81 Fed. Reg. 24,946, 24966 (Apr. 7, 2016)
[13] *Id.*
[14] 82 Fed. Reg. at 38,008-9.

Once the recoupment required under section 631 of the ATRA was complete, the Secretary anticipated making a single positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA. However, section 414 of the MACRA (which was enacted on April 16, 2015) replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. In the FY 2017 rulemaking, the Secretary indicated that he would address the adjustments for FY 2018 and later fiscal years in future rulemaking. As noted previously, section 15005 of the 21st Century Cures Act (Pub. L. 114–255), which was enacted on December 13, 2016, amended section 7(b)(1)(B) of the TMA, as amended by section 631 of the ATRA and section 414 of the MACRA, to reduce the adjustment for FY 2018 from a 0.5 percentage point to a 0.4588 percentage point. The Secretary believes the directive under section 15005 of the Public Cures Act is clear. Therefore, in the FY 2018 IPPS/LTCH PPS proposed rule for FY 2018, the Secretary proposed to implement the required +0.4588 percentage point adjustment to the standardized amount. This is a permanent adjustment to payment rates.[15]

The FY 2018 Federal Register (August 14, 2017)

The Federal Register comments to the FY 2018 Final IPPS Rule, included the following:

> Several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FY 2017 under section 631 of the ATRA, which exceeded the estimated adjustment of approximately -0.8 percentage point described in the FY 2014 IPPS/LTCH PPS rulemaking. **Commenters contended that, as a result, hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA. They asserted that CMS' proposal to apply a 0.4588 percent positive adjustment for FY 2018 misinterprets the relevant statutory authority, and urged CMS to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FY 2018; that is, the difference between the -1.5 percentage point adjustment made in FY 2017 and the initial estimate of -0.8 percentage point discussed in the FY 2014 IPPS/LTCH PPS rulemaking.** Commenters also urged CMS to use its discretion under section 1886(d)(5)(I) of the Act to increase the FY 2018 adjustment by 0.7 percentage point. Other commenters requested that, despite current law, CMS ensure that adjustments totaling the full 3.9 percentage points withheld under section 631 of the ATRA be returned.
>
> *Response:* As discussed in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56783 through 6785), CMS completed the $11 billion recoupment required under section 631 of the ATRA. We continue to disagree that

[15] *Id.* at 38009.

> section 414 of the MACRA was intended to augment or limit our separate obligation under the ATRA to fully offset $11 billion by FY 2017, as we discussed in response to comments in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56784). Moreover, as we discussed in the FY 2018 IPPS/LTCH PPS proposed rule, we believe the directive regarding the applicable adjustment for FY 2018 is clear. While we had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA, section 414 of the MACRA requires that we not make the single positive adjustment we intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. As noted by the commenters, and discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, section 414 of the MACRA would not fully restore even the 3.2 percentage point adjustment originally estimated by CMS in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50515). Finally, Public Law 114–255, which further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point, was enacted on December 13, 2016, after CMS proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under section 631 of the ATRA in the FY 2017 rulemaking.
>
> After consideration of the public comments we received, we are finalizing the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under section 15005 of Public Law 114–255. (emphasis added)[16]

Providers' Request for EJR

The Providers contend the Secretary's refusal to restore the additional 0.7 percent ATRA reduction in the FFY 2018 IPPS Final Rule violates the Administrative Procedures Act because it is inconsistent with the statute and, therefore, is "not in accordance with law." [17] The Providers believe that the Secretary erroneously concluded that the additional 0.7 percent ATRA reduction was intended to continue under MACRA and the 21st Century Cures Act. In reaching this conclusion, the Secretary stated that he lacked discretion to adopt any other position because "the directive regarding the applicable adjustment for FY 2018 is clear."[18] Therefore, the Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for 2018, as required by section 15005 of the 21st Century Cures Act. The Providers assert that the Secretary wholly disregarded the requirements of section 7(b)(2) of the TMA.

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[16] 82 Fed. Reg. at 38009.
[17] 5 U.S.C. § 706(2)(A).
[18] 82 Fed. Reg. at 38009.

The Providers believe that whatever Congress may have intended with the amendment of ATRA section 631(b), by MACRA section 414 and the 21st Century Cures section 15005, it is clear that Congress did not intend to create a large, on-going negative adjustment to the IPPS standardized amount. Despite amending section 7(b) of the TMA with the passage of ATRA, MACRA and the 21st Century Cures Act, Congress has retained the requirement that each "adjustment made under [section 7(b)(1)(B)] for discharges occurring in a year. . .not be included in the determination of the standardized occurring in a subsequent fiscal year." The Providers posit that the Secretary's decision to only adjust the standardized amount by +0.4588 percentage points in FFY 2018 and its stated plan to increase the adjustment to the standardized amount by 0.5 percentage points in FFYs 2019 through 2023 would improperly create a permanent negative reduction to payment rates in the form a residual ATRA adjustment of negative 0.9412 in FY 2024. The Providers assert that this is contrary to the interpretation of ATRA that the Secretary has repeatedly advanced and that was left unaltered by Congress in the MACRA and the 21st Century Cures Act amendments. Instead, the Providers argue, the Secretary is obligated to fully restore the ATRA adjustment by FY 2024 by applying the positive adjustments specified in section 414 of MARCRA as amended by section 15005 of the 21 Cures Act, restoring in FFY 2018 the allegedly excess 0.7 percentage point negative adjustments applied in FY 2017 and not addressed by Congress, and in 2024, making a final positive adjustment to fully offset the remaining ATRA adjustments (*i.e.*, 0.2412 percentage points).

The Providers also argue that the Secretary improperly concluded that he lacks the authority to apply the "exceptions and adjustments" authority under 42 U.S.C. § 1395ww(d)(5)(I) and failed to provide a rationale for declining to exercise that authority in this instance. The Secretary failed to use his authority under the statute to apply a positive adjustment of 0.7 percent in addition to the 0.4588 percent adjustment required under the 21st Century Cures Act.

Decision of the Board

The Board concludes that it lacks the authority to grant the relief sought by the Providers, to apply a positive adjustment of 0.7 percent to the IPPS standard amount. Consequently, the Board hereby grants the Providers' request for EJR for the issue and FFY under dispute. Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1), 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. In this case, the Providers filed a timely appeal of the August 14, 2017 Federal Register notice[19] and the amount in controversy exceeds the $50,000 threshold for jurisdiction over a group.[20] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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[19] In accordance with the Administrator's decision in *District of Columbia Hospital Association Wage Index Group Appeal,* (HCFA Adm. Dec. January 15, 1993) *Medicare & Medicaid Guide* (CCH) ¶ 41,025, a notice published in the Federal Register is a final determination.

[20] *See* 42 C.F.R. § 405.1837.

The Board finds that:

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

2) based upon the participants' assertions regarding the 0.7 percent reduction to the IPPS standardized amount, 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 the 0.7 percent reduction to the IPPS standardized amount, is valid.

Accordingly, the Board finds that the question of the validity of the 0.7 percent reduction to the IPPS rate 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 the case.

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Evaline Alcantara, Noridian Healthcare Solutions (Certified Mail w/ Schedule of Providers)
Wilson Leong, FSS (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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FEB 23 2018

CERTIFIED MAIL

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RE: Jurisdiction Decision
St. Alexius Medical Center
Provider. No. 35-0002
FYE 6/30/2011
PRRB Case No. 14-3676

Dear Mr. Ravindran and Mr. Bloom,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdiction documents in the above-referenced appeal. The Board finds that it does not have jurisdiction over the last issue in the appeal: Medicaid Eligible Days. The decision is set forth below.

Background

On January 13, 2014, the Provider, St. Alexius Medical Center, was issued an original Notice of Program Reimbursement ("NPR") for fiscal year end ("FYE") 6/30/2011. The Provider filed its appeal request with the Board on June 17, 2014, in which it appealed 3 issues: DSH/SSI Percentage (Provider Specific); DSH – Medicaid Eligible Days; and DSH – Medicaid Eligible Observation Bed Days. The Provider separately filed the SSI Systemic Errors issue directly into case no. 14-3310G, QRS 2011 DSH SSI Percentage Group.

The Medicare Contractor filed a jurisdictional challenge with the Board over two issues: Medicaid Eligible Days and Medicaid Eligible Observation Bed Days on April 27, 2015. The Provider responded to the jurisdictional challenge on May 27, 2015. In the same letter, the Provider requested to withdraw the Medicaid Observation Bed Days issue. On May 29, 2015, the Provider filed a second Jurisdictional Challenge over the SSI Provider Specific issue. The Provider responded to the second jurisdictional challenge on June 19, 2015, and again indicated that it was withdrawing the Medicaid Observation Bed Days issue.

In its Final Position Paper, the Provider identified three issues: SSI percentage; Medicaid eligible days; and Medicaid Eligible Observation Bed Days.

On February 14, 2018, the Provider submitted a request to withdraw the SSI Provider Specific issue from this appeal.

Medicare Contractor's Contentions:

Issue 1 – SSI Provider Specific

The Provider withdrew this issue, therefore the Board will not address the jurisdictional challenge as the issue is no longer pending in the appeal.

Issue 2 – Medicaid Eligible Days

The Medicare Contractor argues that the Board does not have jurisdiction over the Medicaid Eligible Days issue because the Provider did not include a claim for the specific item on its cost report, nor did it self-disallow the days by protesting them on the cost report. The Medicare Contractor concludes that the Provider did not preserve its right to claim dissatisfaction with those days in accordance with 42 C.F.R. § 405.1835(a).

Issue 3 – Medicaid Eligible Observation Bed Days

The Provider withdrew this issue, therefore the Board will not address the jurisdictional challenge as the issue is no longer pending in the appeal.

Provider's Contentions:

Medicaid Eligible Days

The Provider argues that the Board has jurisdiction over the Medicaid eligible days issue because there was an adjustment to its DSH payment on its cost report. Additionally, the Provider argues that the necessary documentation for Medicaid eligible days is not available from the State in time, therefore the days were self-disallowed on its cost report.[1]

Board's Decision

Medicaid Eligible Days

The Provider is appealing from a 6/30/2011 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if

[1] Provider's Jurisdictional Response at 7.

it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider **has preserved its right to claim dissatisfaction . . . by . . . [i]ncluding a claim for specific item(s) on its cost report...or...self-disallowing the specific item(s) by . . . filing a cost report under protest.**[2]

The Provider cited to adjustments and also indicated that the issue was self-disallowed in its appeal request. There is nothing in the record to indicate that the Provider claimed eligible days on its cost report or that it included the days as a protested amount. Therefore, the Board finds that it does not have jurisdiction over the eligible days issue.

Conclusion

The Provider has withdrawn the Medicaid Eligible Observation Bed Days and SSI Provider Specific issues. The only issue pending in the appeal is the Medicaid Eligible Days issue. The Board finds that it does not have jurisdiction over the Medicaid Eligible Days issue because the Provider did not claim or protest the days on its 6/30/2011 cost report and dismisses the issue from this appeal.

As no issues remain pending in the appeal, PRRB Case No. 14-3676 is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, FSS

[2] 42 C.F.R. § 405.1835(a).

13-2674G

DEPARTMENT OF HEALTH & HUMAN SERVICES

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FEB 2 3 2018

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RE: Jurisdictional Decision
Provider: Rapid City Regional Hospital
Case Number: 13-1300
FYE: 06/30/2008

Dear Mr. Ravindran and Ms. VanArsdale:

Background

Rapid City Regional Hospital is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in a Notice of Program Reimbursement ("NPR") dated March 8, 2013. The Provider filed a timely appeal from the NPR on March 28, 2013. The Model Form A – Individual Appeal Request (March 26, 2013), Tab 3 lists the following seven issues:

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 ('DSH')/Supplemental Security Income ('SSI") (Systemic Errors)" (hereinafter "DSH/SSI Systemic Errors");
3) Issue No. 3 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Days";
4) Issue No. 4 is entitled "Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days";
5) Issue No. 5 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Labor Room Days";

6) Issue No. 6 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
7) Issue No. 7 is entitled "Disproportionate Share Hospital Payment – Outlier Payments" (Fixed Loss Threshold)

The Provider has requested transfers of Issue Nos. 2, 4, 5, 6 and 7 as follows:

1) Issue No. 2 to Case No. 13-2694G. *Model Form D – Request to Transfer Issue to Group Appeal (Nov. 05, 2013);*
2) Issue No. 4 to Case Nos. 13-22306G *Model Form D – Requests to Transfer Issue to Group Appeal (Nov. 05, 2013);*
3) Issue No 5 to Case No. 13-2697G. *Model Form D – Request to Transfer Issue to Group Appeal (Nov. 05, 2013);*
4) Issue No. 6 to Case Nos. 13-2693GG. *Model Form D – Requests to Transfer Issue to Group Appeal (Nov. 05, 2013);*
5) Issue No. 7 to Case Nos. 13-3418G. *Model Form D – Requests to Transfer Issue to Group Appeal (Nov. 05, 2013);*

The Provider has withdrawn Issue No. 3. The only remaining issue is Issue No. 1 addressing DSH/SSI Percentage (Provider Specific). Issue No. 1 is stated in the appeal request as whether or not the Medicare Contractor used the correct SSI percentage in the DSH calculation, and alleges the DSH payment was not determined in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(i). The Issue description states that the 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 claims 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 determination of the SSI percentage.[1]

Issue No. 2, which has been transferred to Case No. 13-2694G, is stated in the appeal request as whether or not the Secretary properly calculated the Provider's DSH SSI percentage, and alleges the DSH payment was not determined in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider states

[1] *See* Model Form A – Individual Appeal Request (Mar. 26, 2013), Tab 3 at 1.

the SSI percentage calculated by CMS and used by the Medicare Contractor to settle the Provider's cost report does not address the deficiencies as described in the *Baystate*[2] case and it also incorporates a new methodology inconsistent with the Medicare statute. The Provider states it is challenging the SSI percentage based on the following reasons:

1) Availability of MEDPAR and SSA records;
2) Paid days vs. Eligible days,
3) Not in agreement with provider's records,
4) Fundamental problems in the SSI percentage calculation,
5) Covered days vs. Total days,
6) Non-Covered Days,
7) CMS Ruling 1498-R & the matching methodology pursuant to Ruling, and
8) Failure to adhere to required notice and comment rulemaking procedures.[3]

The Board has reviewed Issue No. 1, DSH SSI Percentage (Provider Specific), and its jurisdictional decision regarding this issue is set forth below.

Board Decision:

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

The Board finds regarding Issue No. 1, DSH SSI Percentage (Provider Specific), that it has jurisdiction over the issue which challenges the data used to calculate the SSI percentage as there was an adjustment to the SSI percentage (Adj. 45), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that Issue No. 1 is duplicative of Issue No. 2 (DSH SSI Percentage (Systemic Errors)) that was transferred to Case No. 13-2694G. The basis of both Issues is

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[2] *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[3] *See* Model Form A – Individual Appeal Request (Mar. 26, 2013), Tab 3 at 2-10.

that the SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. Issue No. 1 challenging the accuracy of the DSH SSI Percentage data now resides in Case No. 13-2694G and it is therefore dismissed from this appeal.

This appeal is now closed. 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 H. Ziegler, CPA, CPC-A

FOR THE BOARD

Gregory H. Ziegler

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

cc: Wilson Leong, Esq., FSS

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FEB 23 2018

Certified Mail

Stephanie A. Webster, Esq.
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RE: **Expedited Judicial Review Determination**
FYEs 2010, 2011, 2013
PRRB Case Nos.
McKay 2011 SSI Part C Days Group II, PRRB Case No. 15-2214G
McKay 2011 Medicaid Fraction Part C Days Group II, PRRB Case No. 15-2216G
McKay 2010 SSI Part C Days Group II, PRRB Case No. 15-2243G
McKay 2010 Medicaid Part C Days Group II, PRRB Case No. 15-2245G
Geisinger 2013 Medicaid Part C Days Group, PRRB Case No. 16-0813GC
Geisinger 2013 SSI Part C Days Group, PRRB Case No. 16-0814GC

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 1, 2018, request for expedited judicial review (EJR) (received February 2, 2018) for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> Whether "enrollees in [Medicare] 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]

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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]

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

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[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services.

> 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:

> . . . 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:

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[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).
[18] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[19] 69 Fed. Reg. at 49,099.

> . . . *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. The Secretary has not acquiesced to that 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.[23] 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."[24] Further, the Secretary

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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] Providers' EJR Request at 4 citing to Allina 746 F.3d at 1105.
[24] 68 Fed Reg. at 27,208.

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."[25] The Secretary explained that "once a beneficiary has elected to join a Medicare Advantage plan, that beneficiary's benefits are no longer administered under Part A."[26]

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.[27] 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.[28]

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.[29] 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.[30]

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 2010, 2011 and 2013.

For purposes of 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 the issue in dispute when it settled the participant's cost

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[25] *Id.*
[26] *Id.*
[27] 69 Fed Reg. 49,099 (Aug. 11, 2004).
[28] Providers' EJR Request at 5-6.
[29] *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.").
[30] *Id.*

report or the participant must have self-disallowed the appealed issue by filing its cost report under protest.[31]

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[32] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. The Providers which filed appeals from revised NPRs have adjustments to the SSI percentage, as required for jurisdiction. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[33] 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 2010, 2011 and 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 periods 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;

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[31] *See* 42 C.F.R. § 405.1835 (2008).
[32] See 42 C.F.R. § 405.1889(b)(1) (2008).
[33] *See* 42 C.F.R. § 405.1837.

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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FEB 26 2019

CERTIFIED MAIL

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Palmetto GBA
Cecile Huggins
Supervisor, Provider Cost Report Appeals
Internal Mail Code 380, P.O. Box 100307
Camden, SC 29202-3307

RE: Holston Valley Medical Center
Juris. Challenge DSH – SSI (Provider Specific)
PN: 44-0017
FYE: 6/30/2011
PRRB Case Number: 14-1184

Dear Mr. Ravindran and Ms. Huggins,

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

Holston Valley Medical Center ("Holston" or "Provider") filed a timely appeal on March 24, 2015 from its October 2, 2014 Notice of Program Reimbursement ("NPR"). The issues initially raised included:

(1) Disproportionate Share Hospital Payment ("DSH") – Supplemental Security Income ("SSI") (Provider Specific-Realignment)
(2) DSH – SSI(Systemic Error)
(3) DSH-Medicaid Eligible Days
(4) DSH-Managed Care Part C Days-SSI Fraction
(5) DSH-Managed Care Part C Days-Medicaid Fraction
(6) DSH-Medicaid Eligible Labor Room Days
(7) DSH-Part A Dual Eligible Days-SSI Fraction
(8) DSH-Part A Dual Eligible Days-Medicaid Fraction
(9) Outlier Payments-Fixed Loss Threshold

After transfers and withdraws of issues only Issue # 1 remains in the case.[1]

The Medicare Contractor filed a jurisdictional challenge on January 25, 2018 regarding Issue #1, DSH – SSI (Provider Specific). Holston did not file their jurisdictional response.

Medicare Contractor's Position

[1] *See* Medicare Contractor's Jurisdictional Challenge dated January 24, 2018 and Medicare Contractor Position Paper dated December 22, 2017.

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

Provider's Contentions

Holston contends the SSI percentage published by the Centers for Medicare and Medicaid ("CMS") failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year (June 30). Holston further contends it has been unable to analyze the MEDPAR data in order to identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage based on the Federal Fiscal Year, as the data was not released at the time of filing the Positon Paper.[4]

Board Decision

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

Holston 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."[5]

Holston filed its Final Position paper on November 17, 2017 briefing the SSI provider specific issue. The provider mentions the recalculation of the SSI% based on its cost reporting period in the paper, 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.[6]

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).

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[2] Case # 14-3109GC.
[3] *See* Jurisdictional challenge dated January 24, 2018 (Received January 25, 2018).
[4] *See* Provider's Position Paper dated November 14, 2017.
[5] See Providers Individual Appeal Request dated December 2, 2013.
[6] See Provider's Final Position Paper, page 9.

The Board finds that it has jurisdiction over the portion DSH-SSI (Provider) Specific issue as it relates to the "errors of omission and commission" as there was an adjustment to the SSI percentage (Adj.15). However, the Board finds that this issue is duplicative of the SSI Systemic Errors issue appealed in Group Case No. Case No. 14-3109GC. As 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 as there are no issues remaining in this appeal the case will be closed.

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

Board Members Participating
L. Sue Andersen, Esq.
Charlotte 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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14-0377 **CERTIFIED MAIL** FEB 2 6 2018

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Byron Lamprecht
Cost Report Appeals
Wisconsin Physicians Service
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Omaha, NE 68164

RE: Jurisdictional Determination
Russell County Medical Center
Provider No.: 49-0002
FYEs: September 30, 2009
PRRB Case Nos.: 14-0377

Dear Mr. Ravindran and Mr. Lamprecht:

This case involves Russell County Medical Center's ("Russell County") appeal of its Medicare reimbursement for the fiscal year ending ("FYE") on September 30, 2009. In response to the Medicare Contractor's Jurisdictional Challenge, the Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed Russell County's jurisdictional documentation. Following review of the documentation, the Board finds that it does not have jurisdiction to hear Russell County's appeal of its Supplemental Security Income ("SSI") percentage "provider-specific" issue, as this issue is already contained within a mandatory Common Issue Related Party ("CIRP") group appeal. As this issue is the only issue involved in the instant appeal, the Board hereby closes this case, as explained below.

Pertinent Facts

On October 30, 2013, the Board received Russell County's Request for Hearing ("RFH") regarding its May 2, 2013 Notice of Program Reimbursement ("NPR"). Within its RFH, Russell County seeks Board review of nine issues, including an SSI percentage "provider-specific" issue and an SSI percentage "systemic" issue.

On May 7, 2014, the Board received the Medicare Contractor's Jurisdictional Challenge regarding Russell County's SSI "provider-specific" issue. Within its Challenge, the Contractor argues that Russell County's SSI "provider-specific" issue is not an appealable issue but, rather, a realignment request. Russell County filed a May 23, 2014 Response in which it argues that it "is not addressing a realignment of the SSI percentage, but is addressing the various errors of omission and commission that do not fit into the 'systemic errors' category."[1]

[1] Russell County's May 23, 2014 Response at 1.

Subsequently, Russell County transferred six of its nine issues, including its SSI "systemic" issue, into various group appeals leaving only its SSI "provider-specific" issue and two Medicaid Eligible Days issues in the instant appeal. Then, within its Final Position Paper ("FPP"), Russell County withdrew its Medicaid Eligible Days issues, leaving only its SSI "provider-specific" issue for the Board's consideration in the instant appeal.[2]

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. In addition, two or more providers under common ownership or control that wish to appeal a common, specific issue that arises in cost reporting periods that end in the same calendar year must bring the appeal as a group appeal. Lastly, under Board Rule 4.5 (March 1, 2013), a provider may not appeal an issue from a final determination in more than one appeal.

In its RFH, Russell County summarizes its SSI "provider-specific" issue in the following manner:

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

With respect to its SSI "systemic" issue, Russell County describes the issue as follows:

> The Provider[] challenge[s] [its] SSI percentage[] based on the following reasons:
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days[,] and
> 6. Failure to adhere to required notice and comment rule making procedures.[4]

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[2] Cover Letter of Russell County's FPP.
[3] RFH TAB 3, at unnumbered page 1.
[4] RFH TAB 3, at unnumbered pages 1-2.

In its SSI "systemic" issue statement, Russell County sets out a long list of reasons why it claims that CMS incorrectly computed its SSI percentage. In its SSI "provider-specific" issue statement, Russell County 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 Russell County'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 Russell County's SSI "provider-specific" issue statement includes a proclamation that Russell County "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 Russell County'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.[5] The Board also notes that Russell County's cost reporting period is the *same* as the federal fiscal year underlying the SSI percentage calculation.[6]

As Russell County previously transferred its SSI "systemic" issue into a CIRP group appeal, PRRB Case No. 14-3113GC, the Board hereby dismisses, pursuant to Board Rule 4.5, Russell County's duplicative SSI "provider-specific" issue from the instant appeal.

Conclusion

The Board finds that Russell County's SSI "provider-specific" issue and its SSI "systemic" issue are the same issue. Since Russell County transferred its SSI "systemic" issue to a mandatory CIRP group appeal and, pursuant to Board Rule 4.5, a provider may not appeal an issue from a final determination in more than one appeal, the Board hereby dismisses Russell County's SSI "provider-specific" issue from the instant appeal. As the instant appeal contains no additional issues, the Board hereby closes this case.

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

Board Members Participating:

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

For the Board:

Gregory Ziegler, CPA, CPC-A
Board Member

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

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[5] *See* 42 C.F.R. § 412.106(b)(3) (2015).
[6] For the 2009 cost reporting period, both the federal fiscal year and Russell County's fiscal year end on September 30, 2009.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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FEB 2 6 2018

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Palmetto GBA
Cecile Huggins
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Internal Mail Code 380, P.O. Box 100307
Camden, SC 29202-3307

RE: Holston Valley Medical Center
Juris. Challenge DSH – SSI (Provider Specific) and Medicaid Eligible Days
PN: 44-0017
FYE: 6/30/2011
PRRB Case Number: 15-1950

Dear Mr. Ravindran and Ms. Huggins,

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

Holston Valley Medical Center ("Holston" or "Provider") filed a timely appeal on March 24, 2015 from its October 2, 2014 Notice of Program Reimbursement ("NPR"). The issues initially raised included:

(1) Disproportionate Share Hospital Payment ("DSH") – Supplemental Security Income ("SSI") (Provider Specific-Realignment)
(2) DSH – SSI(Systemic Error)
(3) DSH-Managed Care Part C Days-SSI Fraction
(4) DSH-Part A Dual Eligible Days-SSI Fraction
(5) DSH-Medicaid Eligible Days
(6) DSH-Managed Care Part C Days-Medicaid Fraction
(7) DSH-Part A Dual Eligible Days-Medicaid Fraction
(8) Outlier Payments-Fixed Loss Threshold

After transfers of issues only Issue # 1 and #5 remain in the case.[1]

The Medicare Contractor filed a jurisdictional challenge on January 25, 2018 regarding Issue #1, DSH – SSI (Provider Specific) and Issue #2 DSH-Medicaid Eligible Days. Holston did not file their jurisdictional response.

Medicare Contractor's Position

[1] *See* Medicare Contractor's Jurisdictional Challenge dated January 24, 2018 and Medicare Contractor Position Paper dated September 26, 2017.

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

Medicaid Eligible Days
The Medicare Contractor contends the Board doesn't have jurisdiction over the additional Medicaid eligible days under 42 C.F.R. §405.1835, since the Medicare Contractor did not make an adjustment to disallow the disputed days. The Medicare Contractor emphasizes that the Provider cites adjustments 1, 6, 10, 11, 12 and "self-disallowance" as the source of dissatisfaction. However adjustments 1, and 6, are for Medicare Settlement and Adjustment 11and 12 deal with SSI and General DSH adjustment. The Medicare Contractor further contends even though Adjustment #10 increases Medicaid HMO days and Out of State paid days, these adjustments do not render a determination over the disputed days.[4]

Provider's Contentions

Provider Specific SSI
Holston contends the SSI percentage published by the Centers for Medicare and Medicaid ("CMS") failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year (June 30). Holston further contends it has been unable to analyze the MEDPAR data in order to identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage based on the Federal Fiscal Year, as the data was not released at the time of filing the Positon Paper.[5]

Medicaid Eligible Days
Holston has not yet submitted its Jurisdictional Response to the submitted Challenge.

Board Decision

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

Provider Specific SSI
Holston 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

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[2] Case # 15-0522GC.
[3] *See* Jurisdictional challenge dated January 24, 2018 (Received January 25, 2018).
See Jurisdictional challenge dated January 24, 2018 (Received January 25, 2018) at 6-7.
[5] *See* Provider's Position Paper dated November 29, 2017.

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]

Holston filed its Final Position paper on November 29, 2017 briefing the SSI provider specific issue. The provider mentions the recalculation of the SSI% based on its cost reporting period in the paper, 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 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.11). However, the Board finds that this issue is duplicative of the SSI Systemic Errors issue appealed in Group Case No. Case No. 15-0522GC. As 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).

Medicaid Eligible Days

After reviewing Holston's Individual Appeal Request and the Position Papers the Board finds that the Provider did not submit any supporting documentation that indicates that the Medicare Contractor made an adjustment to disallow the disputed days or that the days the Provider is making a claim for were filed under Protest on the Medicare Cost Report. The Provider further acknowledges they submitted a fiscal year 2011 cost report that does not reflect an accurate number of Medicaid Eligible days as required by HCFA Ruling 97-2.[8] The regulation at 42 C.F.R. § 405.1835(a)(1) provides, in relevant part:

> (a) A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, only if --
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either –
>
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report

[6] See Providers Individual Appeal Request dated March 24, 2015.
[7] See Provider's Final Position Paper, page 9.
[8] See Provider's Final Position Paper, page 8.

> under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).

Per Board Rule 7.2 C :

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

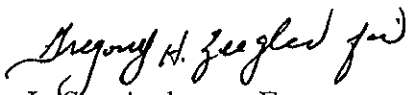
Holston did not include a protested amount on W/S E Part A, L. 70 and they did not document that a claim included a request for additional Medicaid Eligible Days was adjusted. The Board finds that Holston failed to claim the Medicaid eligible days nor did they provide documentation that the cost report included a claim for additional Medicaid Eligible Days. The Provider also acknowledged that the additional Medicaid Eligible Days were not identified on the filed cost. Therefore the appealed issue of Medicaid Eligible Days in this instance does not meet the jurisdictional requirements of the 42 C.F.R. § 405.1835(a)(1) and Board Rule 7.2(C).

As there are no issues remaining in this appeal the case will be closed. Review of this determination 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 H. Ziegler, CPA, CPC-A

FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Certified Mail

FEB 2 6 2018

Robert L. Roth, Esq.
Hooper, Lundy and Bookman, P.C.
401 9th Street, NW
Suite 550
Washington, D.C. 20004

RE: HLB FY 2010 DSH Medicare Part C Days/SSI Fraction Group
Provider Nos. Various
FYE 2010
PRRB Case No. 18-0794G

Dear Mr. Roth:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 9, 2018 request for expedited judicial review (EJR) (received February 9, 2018) for the above-referenced appeal. The Board's determination is set forth below.

Issue in Dispute

The issue in dispute in this appeal is:

> W]hether the Hospitals' FY [Federal Year] 2010 DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

[1] Providers' February 9, 2018 EJR Request at 2.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

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

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

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

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

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

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

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

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. The Secretary has not acquiesced to that decision.

Providers' Request for EJR

The Providers believe that by virtue of the statute, Medicare Part C days should not be included in either the numerator or denominator of the Medicare/SSI fraction.[21] The Providers point out that in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), hospital inpatients who are "entitled to benefits under Part A" are to be included in the Medicare/SSI fraction, with all such patients in the denominator and those who are also entitled to SSI in the numerator. Patients enrolled in a Medicare Part C plan may be "eligible" for Part A, but are not "entitled" to Part A benefits during the months when they have given up their Part A entitlement to enroll in Part C. As a result, the Providers assert, inpatient days associated with these patients do not belong in the Medicare/SSI fraction.

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal[22] because the providers' appeals were timely filed and the $50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the 2004 rule [codified in the 2005 regulation at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B)].[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

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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] Providers' EJR request at 2.
[22] *See* 42 C.F.R. § 405.1837.
[23] *See* 42 C.F.R. § 405.1842(f)(1).

conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Jurisdictional Determination

The participants that comprise the group appeal within this EJR request have filed appeals involving fiscal year 2010.

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

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[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 appeal in this EJR request span fiscal year 2010, thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

Charlotte Benson

L. Sue Andersen, Esq.
Chairperson

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

cc: Laurie Polson, Palmetto GBS c/o NGS (Certified Mail w/Schedule of Providers)
Wilson Leong, (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
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FEB 26 2018

Certified Mail

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

RE: **Expedited Judicial Review Decision**
Akin Gump/Tenet FY 2009 DSH/SSI Medicaid Part C Days Group
PRRB Case No. 13-1962GC[1]

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 26, 2018 request for expedited judicial review (EJR) (received January 29, 2018) for the above-referenced appeal. The Board's determination is set forth below.

Issue in Dispute

The issue in this appeal is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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[1] On January 24, 2018, the Board consolidated 2009 Tenet appeals of the Part C Medicaid and SSI issue; 13-1961GC, 14-0506GC and 14-0507GC into 13-1962GC. On the final schedule of providers for 13-1962GC, many participants are listed twice. This is due to the consolidation of the Medicaid and SSI fraction appeals for the Part C issue into one appeal.
[2] January 26, 2018 EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.
[4] *Id.*

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[19] (emphasis added)

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[21] vacated the FFY 2005 IPPS rule. The Secretary has not acquiesced to that decision.

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

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

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

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

since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdictional Determination

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

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost reports for the period where the providers seek payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing cost reports under protest.[24]

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[25] The Board notes that all participants revised NPR appeals included within this EJR request were issued after August 21, 2008.

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

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[24] 42 C.F.R. § 405.1835(a)(1) (2008).
[25] See 42 C.F.R. § 405.1889(b)(1) (2008).
[26] *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the providers' request for EJR for the issue and the subject year. The Providers have 60

days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

cc: Mounir Kamal, Novitas Solutions (Certified Mail w/Schedule of Providers)
Wilson Leong, (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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FEB 2 6 2018

Certified Mail

Christopher L. Keough
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1333 New Hampshire Avenue, NW
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RE: **Expedited Judicial Review Determination**
Akin Gump/Tenet FY 2008 DSH/SSI Medicaid Part C Days Group
PRRB Case No. 14-3232GC[1]

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 26, 2018 request for expedited judicial review (EJR) (received January 29, 2018) for the above-referenced appeal. The Board's determination is set forth below.

Issue in Dispute

The issue in this appeal is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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[1] On January 24, 2018, the Board consolidated 2008 Tenet appeals of the Part C Medicaid and SSI issue; 14-3230GC, 14-0559GC and 14-0562GC into 14-3232GC. On the final schedule of providers for 14-3232GC, many participants are listed twice. This is due to the consolidation of the Medicaid and SSI fraction appeals for the Part C issue into one appeal.
[2] January 26, 2018 EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

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

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

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

since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2008.

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*.[24]

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]

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

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[24] 485 U.S. at 399 (1988). Under the facts of *Bethesda*, the Board initially found that it was without jurisdiction to review the providers' challenge to the Secretary's regulation regarding apportionment of malpractice insurance costs because the providers had "self-disallowed" the costs in their respective cost reports filed with the Medicare contractor. The Supreme Court held that "[t]he Board may not decline to consider a provider's challenge to a regulation of the Secretary on the ground that the provider failed to contest the regulation's validity in the cost report submitted to [the Medicare Contractor]." The Court went on to state that "the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations."

[25] 42 C.F.R. § 405.1835(a)(1) (2008).

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

The Providers listed below appealed revised NPRs that did not adjust the Medicare Part C Days issue in the revised NPR as required for Board jurisdiction under 42 C.F.R. § 405.1889(b)(1). The Board hereby dismisses the following participants:

9 and 10 Desert Hospital
#11 and 12 Doctors Medical Center of Modesto
#13 and 14 Los Alamitos Medical Center
#19 and 20 North Shore Medical Center
#21 and 22 Hialeah Hospital
#55 and 56 St. Louis University Hospital
#57 and 58 Creighton University Medical Center
#59 and 60 Frye Regional Medical Center
#64 and 65 St. Francis Bartlett Medical Center
#66 and 67 Providence Memorial Hospital
#68 and 69 Houston Northwest Medical Center
#75 and 76 Doctors Hospital at White RockLake

 # 15 and 16 Placentia Linda Hospital

The Board hereby dismisses # 15 and 16 Placentia Linda Hospital because its appeals were not timely filed and there is not good cause for late filing.[27] The Provider's revised NPR was issued on February 24, 2015. The Provider filed an appeal through correspondence dated August 19, 2015; however, the Board did not receive the hearing request until September 21, 2015 (209 days after the issuance of the revised NPR). In a September 17, 2015 letter, the Provider explained that the original hearing request was returned to the sender because the Group Representative's "Admin" had been on vacation and he addressed the envelope himself, but did not include the Board's address on the envelope. The Group Representative stated that he hoped that the Board would consider the error "correctable" and accept the filings. The Board concludes that addressing the envelope to the Board was within the Provider's control. This was not a circumstance in which the Provider could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike).[28]

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[27] *See* 42 C.F.R. § 405.1836:

> a) A request for a Board hearing that the Board receives after the applicable 180–day time limit prescribed in § 405.1835(a)(3) or § 405.1835(c)(2) must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider.
> (b) The Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180–day limit specified in § 405.1835(a)(3) or § 405.1835(c)(2).

[28] *Id.* at § 405.1836(b).

In the alternative, even if there was good cause for late filing, the Provider's revised NPR did not adjust the Medicare Part C days issue as required for Board jurisdiction under the provisions of 42 C.F.R. § 405.1889(b). As a result, the Provider would be dismissed from the appeal under this alternative basis.

 # 17 and 18 University of Southern California
#29 and 30 Good Samaritan Medical Center

The revised NPRs for both Providers were issued on July 17, 2014 and their hearing request[29] was received in the Board's offices on February 3, 2015, 189 days after the issuance of the revised NPRs. The Board finds that the appeal for both Providers was not timely and dismisses the Providers from the appeal. Pursuant to 42 C.F.R. § 405.1835(a)(3), an appeal is timely if the date of receipt by the Board of the provider's hearing request is no later than 180 days after receipt by the provider of the contractor's determination. The final determination is deemed received 5 days after mailing.[30]

In the alternative, the University of Southern California's revised NPR did not adjust the Medicare Part C Days issue as required for Board jurisdiction under the provisions of 42 C.F.R. § 405.1889(b). As a result, the Provider would be dismissed from the appeal under this alternative consideration.

Since jurisdiction over a provider's appeal is a prerequisite to granting a request for EJR, the Board hereby denies the request for EJR for the Providers above for which the Board found that it did not have jurisdiction. *See* 42 C.F.R. §§ 405.1842(b)(1) and (f)(1)(i).

The Remaining Providers

The Board has determined that remaining participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. The Providers which filed appeals from revised NPRs have adjustments to the SSI percentage, as required for jurisdiction. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[31] and the appeal was timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request spans the fiscal year 2008, thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina*

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[29] The Providers' both appealed in a hearing request dated January 8, 2015. See Tab B of the jurisdiction documents for both Providers.
[30] *See* 42 C.F.R. § 405.1801(a)(1)(ii).
[31] *See* 42 C.F.R. § 405.1837.

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

Board's Decision Regarding the EJR Request

The Board finds that:

1) it has jurisdiction over the matter for the subject year and that the remaining participants in this group appeal 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 year. The providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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FEB 2 6 2018

Certified Mail

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RE: **Expedited Judicial Review Determination**
Akin Gump/Tenet FY 2007 DSH/SSI Medicaid Part C Days Group
PRRB Case No. 14-3343GC[1]

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 26, 2018 request for expedited judicial review (EJR) (received January 29, 2018) for the above-referenced appeal. The Board's determination is set forth below.

Issue in Dispute

The issue in this appeal is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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

[1] On January 24, 2018, the Board consolidated 2007 Tenet appeals of the Part C Medicaid and SSI issue; 14-3342GC, 14-1364GC and 14-1365GC into 14-3343GC. On the final schedule of providers for 14-3343GC, many participants are listed twice. This is due to the consolidation of the Medicaid and SSI fraction appeals for the Part C issue into one appeal.
[2] January 26, 2018 EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

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

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

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

since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2007.

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.*[24]

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[25] The Board notes that all participants with revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Providers listed below appealed revised NPRs that did not adjust specifically adjust the Medicare Part C issue in the revised NPR as required for Board jurisdiction under 42 C.F.R. § 405.1889(b)(1). The Board hereby dismisses the following Providers:

8 Los Alamitos Medical Center
9 Fountain Valley Regional Hospital & Medical Center
14 Irvine Medical Center
18 Palmetto General Hospital
19 & 20 West Boca Medical Center
38 Piedmont Medical Center

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[24] 485 U.S. at 399 (1988). Under the facts of *Bethesda*, the Board initially found that it was without jurisdiction to review the providers' challenge to the Secretary's regulation regarding apportionment of malpractice insurance costs because the providers had "self-disallowed" the costs in their respective cost reports filed with the Medicare contractor. The Supreme Court held that "[t]he Board may not decline to consider a provider's challenge to a regulation of the Secretary on the ground that the provider failed to contest the regulation's validity in the cost report submitted to [the Medicare Contractor]." The Court went on to state that "the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations."

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

43 & 44 Nacogdoches Medical Center
45 Park Plaza Hospital
50 Cypress Fairbanks Medical Center
52 Lake Point Medical Center
53 Centennial Medical Center

 # 23 North Fulton Medical Center

The Board hereby dismisses # 23 North Fulton Medical Center because its appeal was not timely filed and there is not good cause for late filing.[26] The Provider's revised NPR was issued on February 24, 2015. The Provider's filed an appeal through correspondence dated August 19, 2015; however, the Board did not receive the hearing request until September 21, 2015 (209 days after the issuance of the revised NPR). In a September 17, 2015 letter, the Provider explained that the original hearing request was returned to the sender because the Group Representative's "Admin" had been on vacation and he addressed the envelope himself, but did not include the Board's address on the envelope. The Group Representative stated that he hoped that the Board would consider the error "correctable" and accept the filings. The Board concludes that addressing the envelope to the Board was within the Provider's control. This was not a circumstance giving rise to good cause because the Provider could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike).[27]

Since jurisdiction over a provider's appeal is a prerequisite to granting a request for EJR, the Board hereby denies the request for EJR for the Providers above for which the Board found that it did not have jurisdiction. *See* 42 C.F.R. §§ 405.1842(b)(1) and (f)(1)(i).

The Remaining Providers

The Board has determined that remaining participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. The Providers which filed appeals from revised NPRs have adjustments to the SSI percentage, as required for jurisdiction. In addition, the participants' documentation

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[26] *See* 42 C.F.R. § 405.1836:

> a) A request for a Board hearing that the Board receives after the applicable 180–day time limit prescribed in § 405.1835(a)(3) or § 405.1835(c)(2) must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider.
> (b) The Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180–day limit specified in § 405.1835(a)(3) or § 405.1835(c)(2).

[27] *Id.* at § 405.1836(b).

shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[28] and the appeal was timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request spans the fiscal year 2007, thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in this request. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

1) it has jurisdiction over the matter for the subject year and that the remaining participants in this group appeal 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

[28] *See* 42 C.F.R. § 405.1837.

grants the providers' request for EJR for the issue and the subject year. The providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

FEB 2 6 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**
Akin Gump/Tenet FY 2005-2006 DSH/SSI Medicaid Part C Days Group
PRRB Case No. 15-1275GC[1]

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 2, 2018 request for expedited judicial review (EJR) (received February 5, 2018) for the above-referenced appeal. The Board's determination is set forth below.

Issue in Dispute

The issue in this appeal is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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[1] On January 24, 2018, the Board consolidated 2005/2006 Tenet appeals of the Part C Medicaid and SSI issue; 16-1253GC, 13-3240GC and 15-1274GC into 15-1275GC. On the final schedule of providers for 15-1275GC, many participants are listed twice. This is due to the consolidation of the Medicaid and SSI fraction appeals for the Part C issue into one appeal.

[2] February 2, 2018 EJR Request at 4.

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

[4] *Id.*

[5] *See* 42 U.S.C. § 1395ww(d)(5).

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[21] vacated the FFY 2005 IPPS rule. The Secretary has not acquiesced to that decision.

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

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

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

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[22] 69 Fed. Reg. at 49,099.
[23] *Allina* at 1109.

since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeal within this EJR request have filed appeals involving fiscal year 2005-2006.

For appeals of original NPRs for cost reporting periods ending before December 31, 2008, the Providers may demonstrate dissatisfaction with the amount of Medicare reimbursement of the Part C days issue by claiming the issue as a "self-disallowed cost" pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*. For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[24] The Board notes that all participants with revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Providers listed below appealed revised NPRs that did not adjust specifically adjust the Medicare Part C issue in the revised NPR as required for Board jurisdiction under 42 C.F.R. § 405.1889(b)(1). The Board hereby dismisses the following Providers:

2 Doctors Medical Center of Modesto
10 and 11 North Shore Medical Center
12 and 13 Coral Gables Hospital
19 Hollywood Medical Center
20 and 21 West Boca Medical Center
22 and 23 Spalding Regional Hospital
40 Centennial Medical Center

Since jurisdiction over a provider's appeal is a prerequisite to granting a request for EJR, the Board hereby denies the request for EJR for the Providers above for which the Board found that it did not have jurisdiction. *See* 42 C.F.R. §§ 405.1842(b)(1) and (f)(1)(i).

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

The Remaining Providers

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

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Request

The Board finds that:

1) it has jurisdiction over the matter for the subject year and that the remaining participants in this group appeal 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

[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 year. The providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

FEB 2 6 2018

Certified Mail

Christopher L. Keough
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RE: **Expedited Judicial Review Determination**
Akin Gump/Tenet FY 2010 DSH/SSI Medicaid Part C Days Group
PRRB Case No. 14-1417GC[1]

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 26, 2018 request for expedited judicial review (EJR) (received January 29, 2018) for the above-referenced appeal. The Board's determination is set forth below.

Issue in Dispute

The issue in this appeal is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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[1] On January 24, 2018, the Board consolidated the 2010 Tenet appeals of the Part C Medicaid and SSI issues. Case 14-1414GC was consolidated into 14-1417GC. On the final schedule of providers for 14-1417GC, many participants are listed twice, which is due to the consolidation of the Medicaid and SSI fraction appeals.
[2] January 26, 2018 EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[21] vacated the FFY 2005 IPPS rule. The Secretary has not acquiesced to that decision.

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

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

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

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

since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeal within this EJR request have filed appeals involving fiscal year 2010.

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.[24]

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[25] The Board notes that all participants with revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Providers listed below appealed revised NPRs that did not specifically adjust the Medicare Part C issue in the revised NPR as required for Board jurisdiction under 42 C.F.R. § 405.1889(b)(1). The Board hereby dismisses the following Providers:

7 & 8 Paradise Valley Hospital
77 & 78 Saint Vincent Hospital

Since jurisdiction over a provider's appeal is a prerequisite to granting a request for EJR, the Board hereby denies the request for EJR for the Providers above for which the Board found that it did not have jurisdiction. *See* 42 C.F.R. §§ 405.1842(b)(1) and (f)(1)(i).

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[24] 42 C.F.R. § 405.1835(a)(1) (2008).
[25] See 42 C.F.R. § 405.1889(b)(1) (2008).

The Remaining Providers

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

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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[26] *See* 42 C.F.R. § 405.1837.

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

Board Members Participating:

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

FOR THE BOARD:

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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FEB 2 7 2018

Certified Mail

Laurence D. Getzoff, Esq.
Hooper, Lundy & Bookman
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2527

RE: **Expedited Judicial Review Determination**

13-0368G	HLB Independent Hospitals 2007 SSI Part C Days
13-0773GC	Sharp HealthCare 2007 DSH – Incl. of Medicare Part C Days in SSI % CIRP Group
13-2746GC	Alta Hospitals System 2008 DSH SSI Part C Days CIRP Group
13-3301G	HLB Naveos Independent Hospitals 2006 DSH SSI Part C Days Group
13-3870G	HLB Independent Hospitals 2006 DSH SSI Part C Days Group
14-0396G	HLB Naveos Independent Hospitals 2009 DSH SSI Part C Days Group
14-4067G	HLB Naveos Independent Hospitals 2010 DSH SSI Part C Days Group
14-4132G	HLB Naveos Independent Hospitals 2011 DSH SSI Fraction Part C Days Group
15-1307G	HLB Independent Hospitals 2011 DSH SSI Fraction Part C Days Group
16-2320G	HLB Naveos Independent Hospitals 2012 DSH SSI Part C Days Group
16-2512G	HLB Naveos II Independent Hospitals 2010 DSH SSI Part C Days Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 12, 2018 requests for expedited judicial review (EJR) (received February 13, 2018) for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> [W]hether the Providers' DSH payments were understated because there were calculated using a SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] February 12, 2018 EJR Requests at 2.

prospective payment system ("PPS").[2] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which

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

> 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.[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]

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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).

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

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

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

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are

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

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

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

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

> *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.[18] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.

Providers' Requests for EJR

The Providers assert that pursuant to the Medicare statute, Medicare Part C days should not be included in either the numerator or denominator of the SSI fraction. In accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), hospital inpatients who are 'entitled to benefits under Part A' are to be included in the SSI fraction, with all such patients in the denominator and those who are also entitled to SSI in the numerator. Patients enrolled in a Medicare Part C plan may be 'eligible' for Part A, but are not 'entitled' to Part A benefits during the months when they have given up their Part A entitlement to enroll in Part C. Accordingly they do not belong in the SSI fraction.

The Providers contend that the Secretary's policy has been inconsistent regarding the treatment for DSH purposes of inpatient days relating to individuals enrolled in Medicare Part C during their hospital stays. In 2003, the Secretary "proposed to clarify" that Medicare Part C days should not be included in the [SSI] fraction." In addition, the Secretary[21] proposed to permit

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

hospitals to counted Medicaid-eligible days in the numerator of the Medicaid fraction. However, this proposal was not finalized that year.[22] In 2004, the Secretary adopted a policy to included Medicare Part C Days in the SSI fraction and exclude those dual-eligible days from the numerator of the Medicaid fraction and stated that the regulations to reflect this policy.[23] However, the regulation was not revised until 2007 when the Secretary stated that she had "inadvertently" failed to revise the regulation earlier. The Providers believe this was done without notice and comment required by 5 U.S.C. § 551 *et seq.* Further, the regulation does not comport with the D.C. Circuit Court decision in *Allina Health Services v. Price*[24] which held that the 2004 rule was invalid because HHS had changed its reimbursement formula without notice providing an opportunity for comment.[25]

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 final IPPS rule that the Board lacks the authority to grant. The Providers maintain that "the Board is required to comply with all regulations issued by the Secretary under the Social Security Act, and is therefore bound to uphold the inclusion of Part C days SSI fraction issue, the Board lacks the authority to make any changes to CMS's policy."[26] Hence, EJR is appropriate.

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within these EJR requests have filed appeals involving fiscal years 2006, 2007, 2008, 2009, 2010, 2011 and 2012.

For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that ends on or before December 30, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[27] With respect to a participant's appeals filed from a cost

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[22] *See* 68 Fed. Reg. 45,346, 45,422 (Aug. 1, 2003).
[23] 69 Fed. Reg. at 49,099 (Aug. 11, 2004).
[24] 863 F.3d 937 (D.C. Cir. 2017).
[25] *Id.* at 938.
[26] Providers' EJR Requests at 5.
[27] 108 S.Ct. 1255 (1988).

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.[28]

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[29] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that participants involved with the instant EJR requests have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. The Providers which filed appeals from revised NPRs have adjustments to the SSI percentage, as required for jurisdiction. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[30] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in these EJR requests span fiscal years 2006, 2007, 2008, 2009, 2010, 2011 and 2012 thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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[28] *See* 42 C.F.R. § 405.1835 (2008).
[29] See 42 C.F.R. § 405.1889(b)(1) (2008).
[30] *See* 42 C.F.R. § 405.1837.

Board's Decision Regarding the EJR Requests

The Board finds that:

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Bruce Snyder, Novitas Solutions (Certified Mail w/Schedules of Providers)
Lorraine Frewert, Noridian (Certified Mail w/Schedules of Providers)
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