DEPARTMENT OF HEALTH & HUMAN SERVICES

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

APR 02 2018

CERTIFIED MAIL

Verrill Dana, LLP
Gary A. Rosenberg, Esq.
One Boston Place, Suite 1600
Boston, MA 02108-4407

National Government Services, Inc.
Pam VanArsdale
Appeals Lead
MP: INA 102-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Yale New Haven Hospital
Provider No. 07-0022
FYE 09/30/2010
PRRB Case No. 14-1434

Dear Mr. Rosenberg and Ms. VanArsdale,

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

Background

Yale New Haven Hospital, the Provider, appealed from an Original Notice of Program Reimbursement (NPR) for the 09/30/2010 cost reporting period dated June 24, 2013. The Provider filed the appeal with the Board on December 19, 2013, and included the following 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 Payment – Medicaid Eligible Days."

The Provider has withdrawn the Medicaid Eligible Days issue.

Separately, the Provider requested to establish a Common Issue Related Party ("CIRP") for the SSI Systemic Errors issue, and directly added this Provider as part of the group appeal request. The Board assigned case no. 14-1443GC to the group.

There is one issue remaining in the appeal: the SSI Provider Specific issue.

Board's Decision

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

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

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was transferred to a group 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 a group appeal.

Because the Systemic Errors issue was directly added to a group appeal, the Board hereby dismisses this aspect of Issue No. 1.

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

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

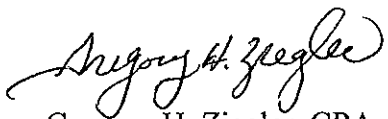
Conclusion

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue in case no. 14-1434 for Yale New Haven Hospital. PRRB Case No. 14-1434 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



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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RE: Saddleback Memorial Medical Center
Provider No. 05-0603
FYE 12/31/2006
PRRB Case No. 13-0845

Dear Ms. Marsden and Ms. Frewert,

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

Background

Saddleback Memorial Medical Center, the Provider, appealed a Revised Notice of Program Reimbursement ("RNPR") for the 06/30/2007 cost reporting period. The RNPR, issued on August 29, 2012, was issued to update the Provider's Disproportionate Share Hospital Payment ("DSH") to include the SSI ratios that CMS published in March 2012.[1]

The Provider filed its individual appeal on February 22, 2013, with the following issues:

1) Supplemental Security Income ("SSI") ratio realignment based on Provider's fiscal year;
2) SSI Ratio Accuracy of the Underlying Data; and
3) SSI Ratio Inclusion of Medicare Part C Days.

On November 1, 2013, the Board received a request to transfer the Medicare Managed Care Part C Days issue and the SSI Ration Accuracy of the Underlying data issue to group appeals.

There is one issue remaining in the appeal, the SSI Realignment issue.

[1] Provider's Individual Appeal Request at 1.

Medicare Contractor's Contentions:

The Medicare Contractor argues that the Board does not have jurisdiction over this issue because a realignment, a change in the computation from the federal fiscal year to the hospital's fiscal year, is a provider election, not a Medicare Contractor final determination.[2] The Medicare Contractor concludes that because a realignment is not a final determination, the Board does not have jurisdiction over the issue pursuant to 42 C.F.R. § 405.1889.

Board's Decision

The Provider identified the SSI Realignment issue with the following language in its appeal request:

> The Provider disputes the accuracy of the SSI ratio utilized by the MAC in the calculation of the capital DSH adjustment. Under current regulations, a hospital may request to have its Medicare fraction recalculated based on the hospital's cost reporting period if that year differs from the Federal fiscal year. Based on the SSI data received from CMS in support of the ratios published in March 2012, the provider has requested realignment of the Medicare fraction.

The Board finds that it does not have jurisdiction over the SSI Realignment issue because there is no final determination with which the Provider can be dissatisfied. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "if 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...." Based on the record before it, the Board finds that there is no final determination with which the Provider can be dissatisfied for appeal purposes.

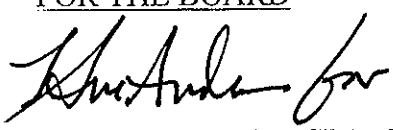
Conclusion

The Board finds that it does not have jurisdiction over the SSI Realignment issue in case no. 13-0845 for Saddleback Memorial Medical Center. PRRB Case No. 13-0845 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



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

[2] Medicare Contractor Jurisdictional Challenge at 1.

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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Mounir Kamal
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RE: Jurisdictional Decision
Provider: Houston Methodist San Jacinto Hospital
Case Number: 15-0427
FYE: 12/31/2010

Dear Ms. Chi and Mr. Kamal:

Background

Houston Methodist San Jacinto Hospital, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. The Provider filed the request for appeal on November 12, 2014 regarding a Notice of Program Reimbursement dated May 23, 2014. There were seven issues stated in the Model Form A – Individual Appeal Request:

1) Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)(hereinafter "DSH SSI Percentage Realignment),

2) Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)(hereinafter "DSH SSI Percentage Provider Specific),

3) Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI")(Systemic Errors)(hereinafter "DSH SSI Percentage Systemic Errors),

4) Disproportionate Share Hospital Payment – Medicaid Eligible Days,

5) Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days,

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

7) Whether Capital IME and DSH were calculated correctly.

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

1) Issue No. 3 to Case No. 15-2917GC,

2) Issue No. 5 (bifurcated) to Case No. 15-2920GC and 15-2921GC, and

3) Issue Nos. 6 (bifurcated) to Case No. 15-1918GC and 15-2919GC.

Issue Nos. 1, 2, 4 and 7 remain in the appeal. The Medicare Contractor has filed a Jurisdictional Challenge regarding Issue Nos. 1 and 2 (Sept. 10, 2015), and has also filed a Jurisdictional Challenge regarding Issue No. 4 (Jan. 22, 2018).

Medicare Contractor's Position

The Medicare Contractor's position is that Issue No. 1 (DSH SSI Percentage Realignment), Issue no. 2 (DSH SSI Percentage Provider Specific), and Issue No. 3 (DSH SSI Percentage Systemic Errors) are the same issue, and therefore Issue Nos. 1 and 2 should be dismissed as duplicative. The Medicare Contractor also asserts that the aspect of Issue No. 1 which preserves the Provider's right to request recalculation of the SSI percentage based upon the Provider's cost reporting period is premature as the Provider has not requested to have its SSI percentage realigned and the Medicare Contractor has not made a final determination regarding this issue. Therefore, the Medicare Contractor asserts this aspect of Issue No. 1 should be dismissed as the Board does not have jurisdiction over this issue.

The Medicare Contractor also alleges the Board does not have jurisdiction over Issue No. 4 (Medicaid Eligible Days) because no adverse determination regarding these disputed days has been made. The Medicare Contractor argues that these days were not claimed on the cost report, nor were they adjusted by the Medicare Contractor, which are both requirements of 42 C.F.R. § 405.1835 for Board jurisdiction. Additionally, the Medicare Contractor claims the Provider has not preserved its right to claim dissatisfaction for this issue as a self-disallowed item in accordance with 42 C.F.R. § 405.1835(a)(1)(ii). In conclusion, the Medicare Contractor asks the Board to dismiss Issue No. 4 from the appeal due to lack of jurisdiction.

The Provider's Position

The Provider filed a Jurisdictional Response (Feb. 15, 2018) addressing the challenged issues. The Provider claims that Issue No. 1 (DSH SSI Percentage Realignment) and Issue No. 2 (DSH SSI Percentage Provider Specific) represent different components of the SSI issue and the Board should find jurisdiction over both issues. The Provider states the DSH SSI Provider Specific issue addresses understated days in the SSI ratio, specifically patients believed to be entitled to both Medicare Part A and SSI, thus it is distinguished from the DSH SSI Systemic Errors issue. The Provider states it is entitled to appeal an item with which it is dissatisfied.

Regarding Issue No. 4, the DSH Medicaid Eligible Days issue, the Provider states there was an adjustment to the Provider's DSH and Medicaid Days (audit adjustment nos. 48 and 54) which is enough to warrant Board jurisdiction over the issue. The Provider then states an adjustment is not required, and the issuance of a Notice of Program Reimbursement and timely appeal properly triggers the Board's jurisdiction over this Provider. The Provider also argues the DSH payment does not have to be adjusted or claimed on a cost report, but rather the Medicare Contractor determines whether or not "to make a DSH adjustment on the published SSI information supplied by CMS and the Medicaid days information supplied by the Provider..."[1] The Provider's position is that jurisdiction is not contingent upon claiming a disputed item on the cost report, and the presentment requirement of 42 C.F.R. § 405.1835(a)(1) is not valid (as it is inconsistent with statute).

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.[2]

[1] Provider's Jurisdictional Response (Feb.15, 2018) at 4.
[2] 42 C.F.R. § 405.1835(a) (emphasis added).

DSH SSI Percentage Data Issues (Nos. 1 and 2)

PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal. Pursuant to 42 C.F.R. 412.106(b)(3), a Provider may request that CMS use its cost reporting period instead of the Federal fiscal year in calculating the SSI percentage of the DSH payment calculation. It must make such a request in writing to its Medicare Contractor.

Issue No. 1 (DSH SSI Percentage Realignment) contends that the "SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation."[3] The Provider also states it "is seeking SSI data from CMS in order to reconcile its records with CMS data…" and that the Provider "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[4] The Provider cites to Adjustment Nos. 48 and 54 regarding this issue, and states an estimated amount in controversy of $49,247.

Identically, Issue No. 2 (DSH SSI Percentage Provider Specific) contends that the "SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation."[5] The Provider also claims it "is seeking SSI data from CMS in order to reconcile its records with CMS data…"[6] The Provider cites to Adjustment Nos. 48 and 54, and states an estimated amount in controversy of $49,247.

The Provider describes Issue No. 3 as "the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the [Medicare Contractor] to settle their Cost Report was incorrectly computed" for the following reasons:

1) Availability of data from MedPAR[7] and SSA[8] Records,

2) Paid Days versus Eligible Days,

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[3] Provider's Model Form A – Individual Appeal Request (Nov. 10, 2014), Tab 3 at 1.
[4] *Id.*
[5] Provider's Model Form A – Individual Appeal Request (Nov. 10, 2014), Tab 3 at 2.
[6] *Id.*
[7] Medicare Provider Analysis and Review Files
[8] Social Security Administration

3) Not in Agreement with Provider's Records,

4) Fundamental Problems in the SSI Percentage Calculation,

5) Covered Days versus Total Days,

6) Non-Covered Days,

7) CMS Ruling 1498-R and the Ruling's Matching Methodology, and

8) Failure to Adhere to Required Notice and Comment Rulemaking Procedures.[9]

The Board finds it has jurisdiction over the portion of Issue No. 1 (DSH SSI Percentage Realignment) and Issue No. 2 (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. 48), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the inaccurate data portion of both Issue Nos. 1 and 2 is duplicative of Issue No. 3, the DSH SSI Percentage Accurate Data issue which was transferred to Case No. 15-2917GC. The basis of all three 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 Nos. 1 and 2 are dismissed from the appeal because they are duplicative of Issue No. 3 (which is prohibited) and the issue now resides in Case No. 15-2917GC.

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 that aspect of Issue No. 1, the DSH SSI Percentage Realignment issue, and it is dismissed from the appeal.

DSH Medicaid Eligible Days Issue (No. 4)

The Provider is appealing from a 12/31/2010 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

As stated above, 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

[9] Provider's Model Form A – Individual Appeal Request (Nov. 10, 2014), Tab 3 at 2-10.

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

The Provider cited to several adjustments, and also indicated that the issue was self-disallowed in its jurisdictional response. While Adjustment No. 54 did add DSH Medicaid Eligible Days, there is nothing in the record to indicate that the Provider claimed the 9 additional Medicaid Eligible Days[10] it now seeks on its cost report or that it included these 9 days as a protested amount. Therefore, the Board finds that it does not have jurisdiction over Issue No. 4 regarding DSH Medicaid Eligible Days.

Issue Nos. 1, 2 and 4 are dismissed from the appeal for the reasons stated above. The appeal will remain open for resolution of Issue No. 7. 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

L. Sue Andersen, Esq.
Chairperson

cc: Wilson Leong, Esq., FSS

[10] *See* Provider's Final Position Paper (Jan. 25, 2018) at 4.

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Pam VanArsdale
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MP: INA 102-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Yale New Haven Hospital
Provider No. 07-0022
FYE 09/30/2008
PRRB Case No. 13-2036

Dear Mr. Rosenberg and Ms. VanArsdale,

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

Background

Yale New Haven Hospital, the Provider, appealed an Original Notice of Program Reimbursement (NPR) for the 09/30/2008 cost reporting period on November 13, 2012. On April 29, 2013, the Provider filed an individual appeal request with the following 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)";
7) Issue No. 7 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Patient Days-Connecticut State Administered General Assistance Outlier Payments

On November 20, 2013, the Board received a request to transfer various issues to group appeals, including the SSI Systemic Errors issue to case no. 13-3850GC.

On June 13, 2016, the Provider withdrew Issue No. 3, Medicaid Eligible Days.

There is one issue remaining in the appeal, SSI Provider Specific, which is relevant to the jurisdictional challenge pending in this appeal.

Board's Decision

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

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

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was transferred to a group 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 a group appeal.

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

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

The second aspect of Issue No. 1—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "if 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 does not have jurisdiction over the SSI Provider Specific issue in case no. 13-2036 for Yale New Haven Hospital.

PRRB Case No. 13-2036 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

Gregory H. Ziegler
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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Nan Chi
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RE: Jurisdictional Decision
Provider: Houston Methodist San Jacinto Hospital
Case Number: 15-0429
FYE: 12/31/2011

Dear Ms. Chi and Mr. Kamal:

Background

Houston Methodist San Jacinto Hospital, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. The Provider filed the request for appeal on November 12, 2014 regarding a Notice of Program Reimbursement dated May 15, 2014. There were seven issues stated in the Model Form A – Individual Appeal Request:

1) Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)(hereinafter "DSH SSI Percentage Realignment),

2) Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)(hereinafter "DSH SSI Percentage Provider Specific),

3) Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI")(Systemic Errors)(hereinafter "DSH SSI Percentage Systemic Errors),

4) Disproportionate Share Hospital Payment – Medicaid Eligible Days,

5) Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days,

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

7) Whether Capital IME and DSH were calculated correctly.

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

1) Issue No. 3 to Case No. 15-2932GC,[1]

2) Issue No. 5 (bifurcated) to Case No. 15-2924GC and 15-2928GC,[2] and

3) Issue Nos. 6 (bifurcated) to Case No. 15-2929GC and 15-2931GC.[3]

Issue Nos. 1, 2, 4 and 7 remain in the appeal. The Medicare Contractor has filed a Jurisdictional Challenge regarding Issue Nos. 1 and 2 (Sept. 10, 2015), and had also filed a Jurisdictional Challenge regarding Issue No. 4 (Jan. 31, 2018).

Medicare Contractor's Position

The Medicare Contractor's position is that Issue No. 1 (DSH SSI Percentage Realignment), Issue no. 2 (DSH SSI Percentage Provider Specific), and Issue No. 3 (DSH SSI Percentage Systemic Errors) are the same issue, and therefore Issue Nos. 1 and 2 should be dismissed as duplicative. The Medicare Contractor also asserts that the aspect of Issue No. 1 which preserves the Provider's right to request recalculation of the SSI percentage based upon the Provider's cost reporting period is premature as the Provider has not requested to have its SSI percentage realigned and the Medicare Contractor has not made a final determination regarding this issue. Therefore, the Medicare Contractor asserts this aspect of Issue No. 1 should be dismissed as the Board does not have jurisdiction over this issue.

The Medicare Contractor also alleges the Board does not have jurisdiction over Issue No. 4 (Medicaid Eligible Days) because no adverse determination regarding these disputed days has been made. The Medicare Contractor argues that these days were not claimed on the cost report, nor were they adjusted by the Medicare Contractor, which are both requirements of 42 C.F.R. § 405.1835 for Board

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[1] *See* Medicare Contractor's Final Position Paper (Feb. 26, 2018) at 1. *See also* Medicare Contractor's Jurisdictional Challenge (Jan. 31, 2018) at 1.

[2] *Id.*

See Medicare Contractor's Final Position Paper (Feb. 26, 2018) at 2. *See also* Medicare Contractor's Jurisdictional Challenge at 1.

jurisdiction. Additionally, the Medicare Contractor claims the Provider has not preserved its right to claim dissatisfaction for this issue as a self-disallowed item in accordance with 42 C.F.R. § 405.1835(a)(1)(ii). In conclusion, the Medicare Contractor asks the Board to dismiss Issue No. 4 from the appeal due to lack of jurisdiction.

The Provider's Position

The Provider filed Jurisdictional Responses (Oct. 2, 2015 and Feb. 21, 2018) regarding the DSH SSI data issues claiming they are separate and distinct issues. The Provider contends with regards to Issue No. 1 (DSH SSI Percentage Realignment) that it is dissatisfied with the period covered by data to calculate the SSI percentage, and that is entitled to receive the detailed data and realign to its fiscal year data. With regards to Issue No. 2 (DSH SSI Percentage Provider Specific) the Provider states it is seeking the data to reconcile its own records and ensure that no patients were omitted from the SSI percentage. With regards to Issue No. 3 (DSH SSI Percentage Systemic Errors), the Provider claims this issue addresses more in-depth aspects of the data including Medicare Part C days and CMS Ruling 1498-R. The Provider states it is entitled to appeal an item it is dissatisfied with and that it can submit data to prove its SSI percentage was understated.

The Provider filed a Jurisdictional Response (Feb. 21, 2018) regarding Issue No. 4, the DSH Medicaid Eligible Days issue, alleging the Medicare Contractor specifically adjusted the Provider's DSH and Medicaid Eligible Days with audit adjustment nos. 4, 25 and 52, and these adjustments are sufficient to warrant Board jurisdiction over this issue. The Provider also argues the DSH payment does not have to be adjusted or claimed on a cost report, but rather the Medicare Contractor determines whether or not "to make a DSH adjustment on the published SSI information supplied by CMS and the Medicaid days information supplied by the Provider..."[4] The Provider's position is that jurisdiction is not contingent upon claiming a disputed item on the cost report, and the presentment requirement of 42 C.F.R. § 405.1835(a)(1) is not valid (as it is inconsistent with statute).

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

[4] Provider's Jurisdictional Response (Feb. 21, 2018) at 4.

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.[5]

DSH SSI Percentage Data Issues (Nos. 1, 2 and 3)

PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal. Pursuant to 42 C.F.R. 412.106(b)(3), a Provider may request that CMS use its cost reporting period instead of the Federal fiscal year in calculating the SSI percentage of the DSH payment calculation. It must make such a request in writing to its Medicare Contractor.

Issue No. 1 contends that the "SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation."[6] The Provider also states it "is seeking SSI data from CMS in order to reconcile its records with CMS data…" and that the Provider "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[7] The Provider cites to Adjustment Nos. 4 and 25 regarding this issue, and states an estimated amount in controversy of $52,247.

Identically, Issue No. 2 contends that the "SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation."[8] The Provider also claims it "is seeking SSI data from CMS in order to reconcile its records with CMS data…"[9] The Provider cites to Adjustment Nos. 4 and 25, and states an estimated amount in controversy of $52,248.

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[5] 42 C.F.R. § 405.1835(a) (emphasis added).
[6] Provider's Model Form A – Individual Appeal Request (Nov. 10, 2014), Tab 3 at 1.
[7] *Id.*
Provider's Model Form A – Individual Appeal Request (Nov. 10, 2014), Tab 3 at 2.
[9] *Id.*

The Provider describes Issue No. 3 as "the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the [Medicare Contractor] to settle their Cost Report was incorrectly computed" for the following reasons:

1) Availability of data from MedPAR[10] and SSA[11] Records,

2) Paid Days versus Eligible Days,

3) Not in Agreement with Provider's Records,

4) Fundamental Problems in the SSI Percentage Calculation,

5) Covered Days versus Total Days,

6) Non-Covered Days,

7) CMS Ruling 1498-R and the Ruling's Matching Methodology, and

8) Failure to Adhere to Required Notice and Comment Rulemaking Procedures.[12]

The Board finds it has jurisdiction over the portion of Issue No. 1 (DSH SSI Percentage Realignment) and Issue No. 2 (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. 25), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the inaccurate data portion of both Issue Nos. 1 and 2 is duplicative of Issue No. 3, the DSH SSI Percentage Accurate Data issue which was transferred to Case No. 15-2932GC. The basis of all three 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 Nos. 1 and 2 are dismissed from the appeal because they are duplicative of Issue No. 3 (which is prohibited) and the issue now resides in Case No. 15-2932GC.

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

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[10] Medicare Provider Analysis and Review Files
[1] Social Security Administration
[12] Provider's Model Form A – Individual Appeal Request (Nov. 10, 2014), Tab 3 at 2-10.

determination regarding this issue. Therefore, the Board does not have jurisdiction over that aspect of Issue No. 1, the DSH SSI Percentage Realignment issue, and it is dismissed from the appeal.

DSH Medicaid Eligible Days Issue (No. 4)

The Provider is appealing from a 12/31/2011 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.

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

The Provider cited to several adjustments, and also indicated that the issue was self-disallowed in its jurisdictional response. While Adjustment No. 4 did add 226 DSH Medicaid Eligible Days, there is nothing in the record to indicate that the Provider claimed the 109 additional Medicaid Eligible Days[13] it now seeks on its cost report or that it included these 109 days as a protested amount. Therefore, the Board finds that it does not have jurisdiction over Issue No. 4 regarding DSH Medicaid Eligible Days.

[13] *See* Provider's Final Position Paper (Jan. 25, 2018) at 4.

Issue Nos. 1, 2 and 4 are dismissed from the appeal for the reasons stated above. The appeal will remain open for resolution of Issue No. 7. 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

L. Sue Andersen, Esq.
Chairperson

cc: Wilson Leong, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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APR 06 2018

Certified Mail

Russell Kramer
Quality Reimbursement Services
150 N. Santa Anita Avenue
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RE: 13-3236GC QRS WFHC 2009 DSH Medicare Managed Care Part C Days Group
13-1375GC Carolinas Healthcare 2008 DSH SSI Fraction Denominator/Part C Days Group
12-0262G QRS 2005 DSH Medicare Managed Care Part C Days Group

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 16, 2018 request for expedited judicial review (EJR) (received March 19, 2018).[1] The decision of the Board with respect to the request for EJR for the above identified cases is set forth below.

Issue for Which EJR was Requested

The Providers requested EJR for the following issue:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).[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] The EJR request also involved case numbers 13-0312GC, 13-0313GC, 13-1383G, 13-2306G and 13-2676G. A decision with respect to those cases will be send under separate cover.
[2] Providers' EJR request at 1.

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

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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).

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

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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).

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:

> . . . *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

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[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.

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

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

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

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

Providers' Position

The Providers point out that the Board is bound by the 2004 Rule found in codified at 42 C.F.R. §§ 405.106(b)(2)(I)(B) and (b)(2)(iii)(B) and the Secretary has not acquiesced to the decision in *Allina Health Services v. Sebelius*. In Allina, the Circuit Court for the District of Columbia issued a vacatur of the 2004 Rule that included Part C Days in the Medicare Fraction of the DSH adjustment and excluded the days from the Medicaid fraction. The Providers contend that the pre-2004 version of the DSH regulation should remain in place, providing that the numerator of the DSH fraction include only "covered patient days that . . . are furnished to patients who, during that month were entitled to both Medicare Part A and SSI."[22]

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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] 42 C.F.R. § 412.106(b)(2)(i)(2003).

The Providers believe that the Board is without the authority to grant the relief they are seeking: an order that Part C Days should be excluded from the Part A/SSI fraction and included in the numerator of the Medicaid fraction. Consequently, they contend 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 and 2009.

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

The Board has determined that participants involved with the instant EJR request 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.

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[23] 108 S.Ct. 1255 (1988).
[24] *See* 42 C.F.R. § 405.1835 (2008).
[25] *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request span fiscal years 2005, 2008 and 2009, 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.

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, List of Cases

cc: John Bloom, Noridian Healthcare Solutions (Certified Mail w/Schedule of Providers)
Laurie Polson, Palmetto GBA c/o NGS (Certified Mail w/Schedule of Providers)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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CERTIFIED MAIL APR 11 2018

James C. Ravindran, President
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RE: Novant 2005-2006 DSH Managed Care/Medicaid Eligible Days Group
PRRB Case No. 08-2580GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the Providers' March 16, 2018 request for expedited judicial review (EJR) (received March 19, 2018). The Board's decision with respect to jurisdiction and the EJR is set forth below.

Issue in Dispute

The issue in dispute in this case is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C.Cir. 2014). ("The Part C Days Issue")[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] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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

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

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]

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[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).
[10] 42 C.F.R. § 412.106(b)(4).

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[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 care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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

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

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[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.
[18] *Id.*

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[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 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 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

Jurisdictional Determination

The participants that comprise the group appeal in this EJR request have filed appeals involving fiscal years 2005 through 2006.

For purposes of Board jurisdiction over a participant's appeal 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

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[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).

as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[23]

The Board has determined that the 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 self-disallowed the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the Providers' appeals were timely filed and the estimated amount in controversy exceeds $50,000, as required for a group appeal.[24] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

Board's Analysis Regarding the Appealed Issue

As noted, the group appeal in this EJR request covers fiscal years 2005 through 2006, 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.

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 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.

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[23] 108 S.Ct. 1255 (1988).
[24] *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 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 case number 08-2580GC.

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Laurie Polson, Palmetto GBA c/o NGS (Certified Mail w/Schedule of Providers)
Wilson Leong, Esq., CPA, Federal Specialized Services (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

APR 1 1 2018

CERTIFIED MAIL

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

RE: QRS Carolinas HealthCare System 2008 Medicaid Fraction Managed Care Part C Days
CIRP Group, PRRB Case No. 14-4029GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the Providers' March 20, 2018 request for expedited judicial review (EJR) (received March 22, 2018). The Board's decision with respect to jurisdiction and the EJR is set forth below.

Issue in Dispute

The issue in dispute in this case is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C.Cir. 2014). ("The Part C Days Issue")[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] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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[1] Providers' EJR request at 1.
[2] *See* 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

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

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]

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[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).
[10] 42 C.F.R. § 412.106(b)(4).

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[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 care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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

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

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[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.
[18] *Id.*

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[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 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 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

Jurisdictional Determination

The participants that comprise the group appeal in this EJR request have filed appeals involving fiscal year 2008.

For purposes of Board jurisdiction over a participant's appeal 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*

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[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).

Hospital Association v. Bowen.[23] With respect to a participant's appeal 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 the 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, self-disallowed, 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 Providers' appeals were timely filed and the estimated amount in controversy exceeds $50,000, as required for a group appeal.[25] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request covers fiscal years 6/30/2008 thru 12/31/2008, 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* 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 year and that the 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;

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[23] 108 S.Ct. 1255 (1988).
[24] *See* 42 C.F.R. § 405.1835 (2008).
[25] *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 case number 14-4029GC.

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Laurie Polson, Palmetto GBA c/o NGS (Certified Mail w/Schedule of Providers)
Wilson Leong, Esq., CPA, Federal Specialized Services (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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CERTIFIED MAIL

APR 1 2 2018

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

RE: QRS Novant 2005 -2006 DSH/Medicare Denominator -Exclusion of Part C Days CIRP
PRRB Case No. 10-0174GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the Providers' March 16, 2018 request for expedited judicial review (EJR) (received March 19, 2018). The Board's decision with respect to jurisdiction and the EJR is set forth below.

Issue in Dispute

The issue in dispute in this case is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C.Cir. 2014). ("The Part C Days Issue")[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] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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

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

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]

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[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).
[10] 42 C.F.R. § 412.106(b)(4).

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[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 care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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

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

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[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.
[18] *Id.*

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[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 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 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

Jurisdictional Determination for Providers

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

[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).

individual appeal or $50,000 or more for a group, and the request for hearing is filed within 180 days of the date of receipt of the final determination.[23]

All of the participants in the subject group appealed from original NPRs that cover cost reporting periods from 2005 through 2006. For purposes of Board jurisdiction over a cost reporting period that ends on or before December 30, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.* (*Bethesda*)[24]

The Board has determined that the 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 self-disallowed the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the Providers' appeals were timely filed and the estimated amount in controversy exceeds $50,000, as required for a group appeal.[25] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

Board's Analysis Regarding the Appealed Issue

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

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

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[23] 42 C.F.R. § 405.1835(a) (2008).
[24] 108 S.Ct. 1255 (1988).
[25] *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 case number 10-0174GC.

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

APR 12 2018

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

RE: QRS Post 10/1/2004 - 2005 DSH Medicare Managed Care/Med Eligible Days Group
PRRB Case No. 07-2389G

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the Providers' March 16, 2018 request for expedited judicial review (EJR) (received March 19, 2018). The Board's decision with respect to jurisdiction and the EJR is set forth below.

Issue in Dispute

The issue in dispute in this case is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C.Cir. 2014). ("The Part C Days Issue")[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] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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

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

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]

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[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(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).
[10] 42 C.F.R. § 412.106(b)(4).

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[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 care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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

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

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[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.
[18] *Id.*

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[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 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 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

Jurisdictional Determination for Providers

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

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[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).

individual appeal or $50,000 or more for a group, and the request for hearing is filed within 180 days of the date of receipt of the final determination.[23]

All of the participants in the subject group appealed from original NPRs that cover cost reporting periods from 10/1/2004 through 2005, except for one that filed from a revised NPR. For purposes of Board jurisdiction over a cost reporting period that ends on or before December 30, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* (*Bethesda*).[24] For revised NPRs issued prior to August 21, 2008, providers must demonstrate that the issue under review was specifically revisited upon reopening.[25]

The Board has determined that the 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 self-disallowed the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the Providers' appeals were timely filed and the estimated amount in controversy exceeds $50,000, as required for a group appeal.[26] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request covers the period from 10/1/2004 through 2005, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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[23] 42 C.F.R. § 405.1835(a) (2008).
[24] 108 S.Ct. 1255 (1988).
[25] For revised NPRs issued prior to August 21, 2008, Board jurisdiction over a provider's revised NPR appeal is assessed under the holding in HCA Health Services v. Shalala, 27 F.3d 614 (D.C. Cir. 1994). In HCA Health Services, the Circuit Court held that when a Medicare contractor reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and the provider appealed this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening, and does not extend further to all determinations underlying the original NPR.
[26] *See* 42 C.F.R. § 405.1837.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes case number 07-2389G.

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: John Bloom, Noridian Healthcare Solutions, LLC (J-F) (Certified w/Schedule of Providers)
Wilson Leong, Esq., CPA, Federal Specialized Services (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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CERTIFIED MAIL

APR 12 2018

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

RE: Blumberg Ribner Independent Hospitals FY 2006 Medicare HMO Days Group, Case 14-0755G
Blumberg Ribner Independent Hospitals FY 2007 Medicare HMO Days Group, Case 14-2430G
Blumberg Ribner Independent Hospitals FY 2008 Medicare HMO Days Group, Case 14-2581G
Blumberg Ribner Independent Hospitals 2007 Medicare HMO Days Group II, Case 16-1733G

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (the Board) has reviewed the Providers' March 26, 2018 request for expedited judicial review (EJR). The Board's decision with respect to jurisdiction and the EJR is set forth below.

Issue in Dispute

The issue in dispute in this case is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C.Cir. 2014). ("The Part C Days Issue")[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] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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[1] Providers' EJR request at 1.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(l); 42 C.F.R. § 412.106.

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

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]

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[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).
[10] 42 C.F.R. § 412.106(b)(4).

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[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 care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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

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

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[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.
[18] *Id.*

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[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 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 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

Jurisdictional Determination

The participants that comprise the group appeal in this EJR request have filed appeals involving fiscal years 2006 through 2008.

For purposes of Board jurisdiction over a participant's appeal 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*

[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).

Hospital Association v. Bowen.[23] With respect to a participant's appeal 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] For appeals of revised NPRs issued after August 21, 2008, the Board only has jurisdiction to hear provider's appeals of matters that the Medicare contractor specifically revised within the revised NPR.[25]

The Board has determined that the 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 self-disallowed the appealed issue such that the Board has jurisdiction to hear their respective appeals: In addition, the participants' documentation shows that the Providers' appeals were timely filed and the estimated amount in controversy for each group exceeds $50,000, as required.[26] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request covers fiscal years 2006 thru 2008, 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;

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[23] 108 S.Ct. 1255 (1988).
[24] *See* 42 C.F.R. § 405.1835 (2008).
[25] *See* 42 C.F.R. § 405.1889(b)(1)(2008).
[26] *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' 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 in each group, the Board hereby closes case numbers 14-0755G, 14-2430G, 14-2581G and 16-1733G.

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Pam VanArsdale, NGS (J-K)(Certified Mail w/Schedule of Providers)
Wilson Leong, Esq., CPA, Federal Specialized Services (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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CERTIFIED MAIL

APR 13 2018

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Quality Reimbursement Services, Inc.
112 N. University Rd., Suite 308
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RE: QRS Univ. of WA Medicine Post 9/30/2004 - 2007 Part C Days CIRP Group
PRRB Case No. 09-1506GC

Dear Mr. Kramer and Mr. Nord:

The Provider Reimbursement Review Board (the Board) has reviewed the Providers' March 16, 2018 request for expedited judicial review (EJR) (received March 19, 2018). The Board's decision with respect to jurisdiction and the EJR is set forth below.

Issue in Dispute

The issue in dispute in this case is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C.Cir. 2014). ("The Part C Days Issue")[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] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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

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

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]

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

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[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 care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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

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

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[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.
[18] *Id.*

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[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 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 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

Jurisdictional Determination for Providers

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

[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).

individual appeal or $50,000 or more for a group, and the request for hearing is filed within 180 days of the date of receipt of the final determination.[23]

All of the participants in the subject group appealed from original NPRs that cover cost reporting periods ending from 10/1/2004 through 2007. For purposes of Board jurisdiction over a cost reporting period that ends on or before December 30, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.* (*Bethesda*)[24]

The Board notes, however, that the following participants are not able to demonstrate that they timely appealed the Part C days issue:

#1 University of Washington (50-0008) FYE 10/1/2004-6/30/2005
#2 University of Washington (50-0008) FYE 6/30/2006
#3 University of Washington (50-0008) FYE 6/30/2007
#5 Harborview Medical Center (50-0064) FYE 6/30/2006
#6 Harborview Medical Center (50-0064) FYE 6/30/2007

The copies of the individual appeals submitted in the associated jurisdictional documentation for the group do not include evidence of the Part C Days issue at their respective Tab B's,[25]nor is there documentation evidencing that the Part C days issue was added to the individual appeals prior to transferring to the group. Therefore, the Board denies jurisdiction over participants #1, #2, #3, #5 and #6. Since jurisdiction over a provider is a prerequisite to granting a request for EJR, these Providers' request for EJR is denied. *See* 42 C.F.R. § 405.1842(a). Review of the jurisdictional determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

The remaining participant in the group, Harborview Medical Center (50-0064) for FYE 10/1/2004-6/30/2005, did submit documentation showing the Part C days issue was appealed. This participant (#4) included the Part C days issue in its individual appeal and subsequently transferred the issue to an optional group (case no. 07-2389G), before it was transferred to a CIRP group (case no. 10-1234GC.) The Board then agreed to bifurcate the period from 10/1/2004 to 6/30/2005 for this participant and transferred it to this group on April 25, 2016. In addition, this participant (# 4) is covered under the self-disallowance provision set forth in *Bethesda* such that the Board has jurisdiction to hear its respective appeal, the Provider's appeal was timely filed and the estimated amount in controversy of the group, prior to dismissal of the participants noted, exceeded the $50,000 threshold.[26] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

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[23] 42 C.F.R. § 405.1835(a) (2008).
[24] 108 S.Ct. 1255 (1988).
[25] Participant #1 appealed only Bad Debts and Participant #2, #3, #5 and #6 did not supply lists of issues behind their appeal requests.
[26] *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

The remaining Provider, Harborview Medical Center, is appealing a partial fiscal year from 10/1/2004 through 6/30/2005, 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 Provider would have the right to bring suit in either the D.C. Circuit *or* the circuit within which it is 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 Harborview Medical Center (participant #4) for the period from 10/1/2004 through 6/30/2005 and that this participant is entitled to a hearing before the Board. The Board denies jurisdiction over the remaining participants as noted above;

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the remaining Provider's request for EJR for the issue and the subject year. The Provider 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 case number 09-1506GC.

Board Members Participating:

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

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
Schedule of Providers

cc: John Bloom, Noridian Healthcare Solutions, LLC (J-F) (Certified w/Schedule of Providers)
Wilson Leong, Esq., CPA, Federal Specialized Services (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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APR 13 2018

Certified Mail

Russell Kramer
Quality Reimbursement Services
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Arcadia, CA 91006

RE: **Expedited Judicial Review**
QRS HMA 2006 DSH Medicare Managed Care Part C Days Group
PRRB Case No. 13-0312GC

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 16, 2018 request for expedited judicial review (EJR) (received March 19, 2018) for the above-referenced appeal. The Board's determination is set forth below.

The issue in these appeals is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the 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]

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

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

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

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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).

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2006.

For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that 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.*[21]

Submission of the Healthcare Provider Cost Reporting Information System (HCRIS) Reports In Lieu of Notices of Program Reimbursement (NPRs)

8 Heart of Florida Regional Medical Center; # 9 Pasco Regional Medical Center; # 10 Seven Rivers Regional Medical Center; # 27 Harton Regional Medical Center; # 29 Medical Center of Central Mesquite

The Providers referenced above submitted HCRIS reports instead of their NPRs, the final determination of Medicare reimbursement for the 2006 cost reporting period. Medicare providers are required to submit an annual cost report to a Medicare Administrative Contractor (previously called Intermediary). The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data. CMS maintains the cost report data in HCRIS.[22] A HCRIS report is not a final determination of Medicare reimbursement. The regulation, 42 C.F.R. § 405.1835(b)(3) (2008), states that a provider must submit a copy of the intermediary determination under appeal as part of its hearing request. Since the Providers did not submit a copy of its intermediary determination as required for Board jurisdiction, the Board hereby dismisses the following Providers from the appeal: # 8 Heart of Florida Regional Medical Center; # 9 Pasco Regional Medical Center; # 10 Seven Rivers Regional Medical Center; # 27 Harton Regional Medical Center; # 29 Medical Center of Central Mesquite. Since jurisdiction over a provider is a prerequisite to granting a request for EJR, these Providers' request for EJR is denied. *See* 42 C.F.R. § 405.1842(a).

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[21] 108 S.Ct. 1255 (1988).
[22] *See* https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/ (last visited April 12, 2018).

EJR Determination

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[23] 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 involves the fiscal years 2006, 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.

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 is 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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[23] *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
Robert A. Everts, Esq.

FOR THE BOARD:

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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APR 13 2018

Certified Mail

Russell Kramer
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RE: **Expedited Judicial Review**
QRS HMA 2007 DSH Medicare Managed Care Part C Days Group
PRRB Case No. 13-0313GC

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 16, 2018 request for expedited judicial review (EJR) (received March 19, 2018) for the above-referenced appeal. The Board's determination is set forth below.

The issue in these appeals is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the 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]

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

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

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

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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).

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2007.

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.*[21]

Submission of the Healthcare Provider Cost Reporting Information System (HCRIS) Reports In Lieu of Notices of Program Reimbursement (NPRs)

Provider # 5 Seven Rivers Regional Medical Center[22] submitted a HCRIS report instead of its NPR, the final determination of Medicare reimbursement for the 2007 cost reporting period. Medicare providers are required to submit an annual cost report to a Medicare Administrative Contractor (previously called Intermediary). The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data. CMS maintains the cost report data in HCRIS.[23] A HCRIS report is not a final determination of Medicare reimbursement. The regulation, 42 C.F.R. § 405.1835(b)(3) (2008), states that a provider must submit a copy of the intermediary determination under appeal as part of its hearing request. Since the Providers did not submit a copy of its intermediary determination as required for Board jurisdiction, the Board hereby dismisses the following # 5 Seven Rivers Regional Medical Center from the case. Since jurisdiction over a provider is a prerequisite to granting a request for EJR, the Provider's request for EJR is denied. *See* 42 C.F.R. § 405.1842(a).

EJR Determination

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[24] 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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[21] 108 S.Ct. 1255 (1988).
[22] This Provider also failed to submit its original hearing request.
[23] *See* https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/ (last visited April 12, 2018).
[24] *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR involves 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 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.[25]

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 is 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

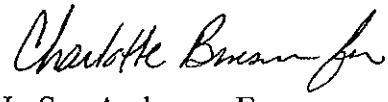
[25] On March 19, 2018, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in a number of cases identified in the EJR request. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina.* The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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
Robert A. Everts, Esq.

FOR THE BOARD:



L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

CERTIFIED MAIL

Provider Reimbursement Review Board
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APR 13 2018

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

RE: QRS 2008 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
CIRP Group, PRRB Case No. 13-2306G

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the Providers' March 19, 2018 request for expedited judicial review (EJR). The Board's decision with respect to jurisdiction and the EJR is set forth below.

Issue in Dispute

The issue in dispute in this case is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C.Cir. 2014). ("The Part C Days Issue")[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] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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

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

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]

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[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).
[10] 42 C.F.R. § 412.106(b)(4).

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[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 care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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

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

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[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.
[18] *Id.*

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[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 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 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

Jurisdictional Determination

The participants that comprise the group appeal in this EJR request have filed appeals involving fiscal year 2008.

For purposes of Board jurisdiction over a participant's appeal 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*

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[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).

Hospital Association v. Bowen.[23] With respect to a participant's appeal 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]

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 participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

Community Memorial Hospital of SB (05-0394); FYE 12/31/2008 (Participant #3)

The Provider's revised NPR which was issued May 17, 2013 is the subject of this appeal. The revised NPR was issued as the result of the Provider's request that the Medicare Contractor reopen the cost report to revise Medicaid eligible days. The Medicare Contractor agreed to reopen the cost report to revise Medicaid eligible days and issued the revised NPR. The Provider identified audit adjustment #4 and #5 which adjusted Medicaid Days and the DSH percentage. Since the Part C days issue that is the subject of this appeal was not revised in the revised NPR, the Board does not have jurisdiction over the Provider's appeal pursuant to 42 C.F.R. § 405.1889. This regulation states that any matter not specifically revised may not be considered in any appeal of the revised determination. The Board hereby dismisses the Provider from the appeal and since jurisdiction is a prerequisite to granting EJR, the Provider's request for EJR is denied.

Mary Lanning Memorial Hospital (Mary Lanning) (28-0032); FYE 12/31/2008 (Participant #29) and Stevens Healthcare (50-0026); FYE 12/31/2008 (Participant #43)[26]

On the Schedule of Providers, Mary Lanning indicated that it self-disallowed the issue and listed audit adjustment #46 which was an adjustment to the allowable DSH percentage. There is no supporting documentation to show the Part C days or SSI Percentage issue was included in the Provider's protested amounts.

Stevens Healthcare also indicated, on the Schedule of Providers, that it self-disallowed the issue and listed audit adjustment #18 which removed amounts reported in protest related to non-allowable general assistance days. There is no supporting documentation to show the Part C days or SSI Percentage issue was included in the Provider's protested amounts.

Because the FYE in dispute for both of these participants ended 12/31/2008 and because neither participant has evidence showing that the SSI percentage was protested, the Board does not have

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[23] 108 S.Ct. 1255 (1988).
[24] *See* 42 C.F.R. § 405.1835 (2008).
[25] See 42 C.F.R. § 405.1889(b)(1).
[26] The FYE reflected on the Schedule of Providers for this participant contains a typographical error and shows 12/31/2009. Based on the documentation submitted, the correct FYE should be 12/31/2008.

jurisdiction pursuant to 42 C.F.R. § 405.1835. The Board hereby dismisses these Providers from the appeal and since jurisdiction is a prerequisite to granting EJR, the Providers' requests for EJR are denied.

Wuesthoff Memorial Hospital (10-0092); FYE 9/30/2008 (Participant #21)

On December 4, 2017, the Board denied jurisdiction over the Medicaid Fraction Part C days issue in the Provider's individual appeal (case no. 13-3106) as the Provider's revised NPR did not adjust the Medicaid Fraction. The Board also denied the transfer of the Medicaid Fraction Part C days issue to the subject group. Therefore, this Provider is not a participant in the group and has been removed from the Schedule of Providers.

Remaining Participants

The Board has determined that the remaining participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction or had a specific adjustment to the SSI fraction, self-disallowed, 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 Providers' appeals were timely filed and the estimated amount in controversy exceeds $50,000, as required for a group appeal.[27] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request covers 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* 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] *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 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 case number 13-2306G.

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.

FOR THE BOARD:

Charlotte Benson for

L. Sue Andersen, Esq.
Chairperson

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

cc: Pam VanArsdale, National Government Services, Inc. (Certified w/Schedule of Providers)
Wilson Leong, Esq., CPA, Federal Specialized Services (w/Schedule of Providers)

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APR 1 3 2018

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RE: **EJR Determination**

14-0868GC HRS FMOLHS 2010 DSH SSI Fraction Medicare Managed Care Part C Days Group
14-1065GC HRS SCHS 2007 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-2485GC HRS FMOLHS 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days Grp
15-2631GC HRS UHHS 2012 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-2632GC HRS UHHS 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
15-3004GC HRS THR 2010 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-3005GC HRS THR 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
15-3006GC HRS THR 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
15-0540GC HRS LSU 2012 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-0541GC HRS LSU 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
15-1878GC HRS WKHS 2012 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-1892GC HRS WKHS 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
15-1967GC HRS SCHS 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
15-1977GC HRS ECHN 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-1979GC HRS ECHN 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
15-3293GC HRS THR 2008 DSH SSI Fraction Medicare Managed Care Part C Days Group

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 21, 2018 requests for expedited judicial review (EJR) (received March 23, 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:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.[1]

[1] Providers' 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]

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

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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 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 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 the Department 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

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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.

> 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 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 contend that the Board should grant their request for EJR.

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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 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 no 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 2007, 2008, 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.*[23] 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]

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 participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

Jurisdictional Determinations

15-0540GC HRS LSU 2012 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-0541GC HRS LSU 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days Group

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[23] 108 S.Ct. 1255 (1988).
[24] *See* 42 C.F.R. § 405.1835 (2008).
[25] See 42 C.F.R. § 405.1889(b)(1) (2008).

Provider # 4 Earl K Long Medical Center indicated on the Schedule of Providers that the Part C days issue in the above-referenced appeals had been self-disallowed. Pursuant to the regulation, 42 C.F.R. § 405.1835(a)(1)(ii) (2008), for cost report periods ending on or after December 31, 2008, a provider has the right to a hearing for an item that may not be allowable on a cost report if the Provider has preserved its right to claim dissatisfaction with the amount of Medicare payments by following the procedures for filing a cost report under protest. Board Rule 21.D. identifies jurisdiction documentation required to demonstrate a claim for protested amounts. This includes a copy of the as-filed cost report protested page and evidence of protest which is the list of items protested that ties to the amount claimed on the cost report and evidences a protest of the issue under appeal. In these cases, the Provider furnished a Worksheet E, Part A with nothing on Line 75 (the line for protested amounts) and no list of protested amounts documenting a claim for Medicare Part C day issue. Since the Provider did not comply with the requirements of the regulation and Board Rule demonstrating it had claimed Part C Days as a protested amount, the Board hereby dismiss Earl K. Long Medical Center from case numbers 15-0540GC and 15-0541GC. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR the Provider's request for EJR is hereby denied. *See* 42 C.F.R. § 405.1842(a).

Case No. 15-1967GC HRS SCHS 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days Group

Provider # 3 Providence Hospital Sisters of Charity previously had the Medicaid Part C Days issue dismissed from its individual appeal on July 9, 2015 in case number 15-0481. Included in that jurisdictional determination was a denial of the request to transfer into the Part C Medicaid fraction group appeal. Since the Board previously denied jurisdiction over this Provider's appeal and transfer, the Provider is dismissed from this case for lack of jurisdiction. Since jurisdiction is a prerequisite to granting EJR, the Provider's request for EJR is hereby denied.

15-1977GC HRS ECHN 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-1979GC HRS ECHN 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days Group

In these cases, the only two Providers in the cases, Rockville General Hospital and Manchester Memorial Hospital, both indicated that adjustment 10 was the subject of their respective appeals. The narrative for adjustment 10 states that it is a "Memo Adjustment" stating that CMS will provide contractors with a notice of the updated SSI data for use in [settling] the cost reports for a particular FFY. . . .After publication of the data, the cost report would be settled after adjusting the [as-filed] SSI [percentage]. The Board hereby finds that it lacks jurisdiction over the Providers and dismisses the Providers from the appeals because they did not have an adjustment to the issue under appeal nor did they furnish evidence they protested the Part C issue as required for Board jurisdiction under 42 C.F.R. § 405.1835. Since the Board lacks jurisdiction over the appeals which is a prerequisite to granting EJR, it hereby denies the Providers request for EJR. The Board hereby closes case numbers 15-1977GC and 15-1979GC because there are no other Providers remaining in the cases.

Case No. 15-3293GC HRS THR 2008 DSH SSI Fraction Medicare Managed Care Part C Days Group

In this case, # 1 Texas Health Harris Methodist Hospital Fort Worth, appealed from a revised NPR and identified adjustment 4 as the subject of the dispute. Adjustment 4 was used to include additional Medicaid eligible days on S-3 and to update the DSH payment calculation. There was no adjustment to the SSI percentage or to Part C Days. The Board finds that it lacks jurisdiction over Texas Health Harris Methodist Hospital Fort Worth because the regulation, 42 C.F.R. § 405.1889(b), limits appeals of revised NPRs to matters that are specifically revised in the revised determination. Since Adjustment 4 did not adjust the SSI percentage or Part C Days the Board does not have jurisdiction over the Provider and dismisses the Provider from the case. Since jurisdiction over a Provider's appeal is a prerequisite to granting jurisdiction, the Board hereby denies the Provider's request for EJR.

EJR Determination for the Remaining Providers

The Board has determined that the remaining 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. 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 these EJR requests span fiscal years 2007, 2008, 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.

Board's Decision Regarding the EJR Request

The Board finds that:

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[26] *See* 42 C.F.R. § 405.1837.

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Mounir Kamal, Novitas (Certified Mail w/Schedules of Providers)
Judith Cummings, CGS Administrators (Certified Mail w/Schedules of Providers)
Pam VanArsdale, NGS (Certified Mail w/Schedules of Providers)
Wilson Leong, FSS (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

APR 1 3 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**
QRS 2006 DSH Managed Care Part C Days
PRRB Case No. 09-0996G

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the March 16, 2018 request for expedited judicial review (EJR) (received March 19, 2018) for the above-referenced appeal. The Board's determination is set forth below.

The issue in this appeal is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the 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]

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

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

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

Providers' Request for EJR

The 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 (b)(2)(iii)(B) (the 2004 Rule). The Board is bound by the 2004 rule 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 no 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

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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.

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 2006.

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.*[22]

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.[23] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

Issue not Included in Original Hearing Request or Added to Individual Appeal before Transfer to the Group

1 Parkview Medical Center, # 4 The William Backus Hospital; # 11 St. Cloud Hospital; #12 Monongahela Valley Hospital; #14 Sanford USD Medical Center; # 15 Baptist St. Anthony Health System; # 27 St. Luke's Episcopal Hospital

The Providers above filed hearing requests which did specifically identify the Part C Days issue as an issue in the hearing request. The Providers transferred the Part C issue to the current group appeal; however, there is no evidence that the Part C issue was ever added to the individual appeals.

Prior to August 21, 2008, the effective date of the Board's revised governing regulations, a provider could add an issue to an appeal prior to the commencement of the hearing proceedings.[24, 25] Effective August 21, 2008, for appeals pending before the Board prior to that date, a provider that wished to added one or more issues to an appeal must have done so within 60 days of the effective date of the new regulations (October 20, 2008) or 60 days after the expiration of the 180-day appeal period, whichever was later.[26] Subsequent to that period, the

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[22] 108 S.Ct. 1255 (1988).
[23] See 42 C.F.R. § 405.1889(b)(1).
[24] 42 C.F.R. § 405.1841(a) (2006).
[25] A number of the individual Provider appeals were filed prior to August 21, 2008, hence, the regulation, 42 C.F.R. § 405.1841(2006) is applicable to a portion of the time some of the cases were pending before the Board.
[26] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

regulation, 42 C.F.R. § 405.1835(c) (2008), permits providers to add issues to a hearing request if the request is received by the Board no later than 60 days after the expiration of the 180-day appeal period. Since there is no evidence that the Providers timely appealed the Part C issue or added the issue to their individual appeals before transferring the issue, as required by 42 C.F.R. §§ 405.1835(c)(2008) and 405.1841(a) (2006), the Board concludes it lacks jurisdiction over the identified Providers because they do not have timely appeals of the Part C days issue. The Board hereby dismisses the following Providers from the case: # 1 Parkview Medical Center; # 4 The William Backus Hospital; # 11 St. Cloud Hospital; #12 Monongahela Valley Hospital; #14 Sanford USD Medical Center; # 15 Baptist St. Anthony Health System; and # 27 St. Luke's Episcopal Hospital. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board denies the Providers' request for EJR.

Revised NPR Appeal

26 Via Christi Regional Medical Center

The Provider's October 16, 2009 revised NPR is the subject of this appeal. The revised NPR was issued as the result of the Provider's request that the Medicare Contractor reopen the cost report to revise eligible, unpaid Medicare deductibles and coinsurance for Medicare/Medicaid crossover days, additional Medicaid eligible days and GME FTEs. The Medicare Contractor agreed to reopen the cost report to revise the costs identified by the Provider and issued the revised NPR revising those matters. Since the Part C days issue that is the subject of this appeal was not revised in the revised NPR, the Board does not have jurisdiction over the Provider's appeal pursuant to 42 C.F.R. § 405.1889. This regulation states that any matter not specifically revised may not be considered in any appeal of the revised determination. The Board hereby dismisses the Provider from the appeal and since jurisdiction is a prerequisite to granting EJR, the Provider's request for EJR is denied.

Lack of Representation Letter

#17 Stevens Healthcare

The Group Representative filed the hearing request in the individual appeal and the transferred the Part C days issue to current group appeal. The jurisdiction documents do not contain a letter from a representative of the Provider authorizing representation by the Group Representative as required by Board Rule 5.4 (a letter designating the representative must be on the Provider's letterhead and signed by the owner or officer of the Provider). Further, the hospital representative did not sign any of the forms for the original hearing request authorizing representation nor did the hospital representative sign the "Request to Transfer Issue to A Group" form authorizing the transfer of the Part C Days issue from the original hearing request to the group appeal. Since the Group Representative has not demonstrated that it is the authorized representative of the Provider as required by Board Rule 5.4 the Board hereby dismisses Stevens Healthcare from the group and denies the Provider's request for EJR.

EJR Determination for 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. 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[28] 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 Provider's cost reporting periods in the appeal are for fiscal year 2006, 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.

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 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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[27] *See* 42 C.F.R. § 405.1837.

[28] Provider # 23 St. Francis Hospital's appeal was received 186 days after the issuance of its NPR. Pursuant to 405.1801(a)(1)(iii) the date of receipt of the final determination by the Provider is presumed to be 5 days after the date of issuance of the final determination. The Provider appeal must be received by the Board no later than 180 days after the date of receipt of the final determination (42 C.F.R. § 1835(a)(3)(i)). In this case, the 180th day was Veterans' Day, a Federal holiday. Under 42 C.F.R. § 405.1803(c)(3), where the last day of a filing period is a Federal legal holiday, the deadline for filing is the next business day, consequently the Provider's appeal is deemed timely..

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

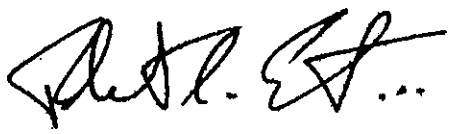
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

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

Board Members Participating:

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

FOR THE BOARD:



Board Member

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

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

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Lorraine Frewert
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P.O. Box 6782
Fargo, ND 58108-6782

RE: Community Hospital of the Monterey Peninsula
Provider No.: 05-0145
FYE: 12/31/11
PRRB Case No.: 16-2271

Dear Ms. Ellis and Ms. Frewert,

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

Background

The Provider submitted a request for hearing on August 18, 2016, based on a Notice of Program Reimbursement ("NPR") dated February 25, 2016. The hearing request included thirteen issues. Eight issues have been transferred to group appeals. One issue was withdrawn. One of the four issues remaining in the appeal is Issue No. 12 – Medicare Disproportionate Share Hospital (DSH) Payments – SSI Ratio Alignment to Provider's Cost Reporting Year. The Medicare Contractor submitted a jurisdictional challenge on this issue on March 30, 2018.

Medicare Contractor's Position

The Medicare Contractor contends that the decision to realign a hospital's SSI percentage is a hospital election, not a Medicare Contractor determination. The Hospital must make a formal request to CMS, through its Medicare Contractor, in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.[1]

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

[1] Medicare Contractor's jurisdictional challenge at 4.

amount of payment due to the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period…".[2]

The Medicare Contractor contends that it did not and cannot make a determination in terms of the Provider's SSI percentage realignment. The only party that can make the election regarding the fiscal year end for the SSI percentage is the Provider. Since there is not a Medicare Contractor determination for the Provider to contest, the Board does not have jurisdiction over this issue, pursuant to 42 C.F.R. § 405.1803. It is the Medicare Contractor's position that realignment is not an appropriate issue to include as an appeal issue.[3]

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

This case is scheduled for a live hearing on August 29, 2018. 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

Charlotte F Benson for

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

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

[2] Medicare Contractor's jurisdictional challenge at 4.
[3] Medicare Contractor's jurisdictional challenge at 4.

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

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Nashville, TN 37202

RE: UHHS/Richmond Medical Center
Provider No. 36-0075
FYE 12/31/2009
PRRB Case No. 15-1947

Dear Ms. Goron and Ms. Cummings,

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

Background

UHHS/Regional Medical Center, the Provider, appealed an Original Notice of Program Reimbursement (NPR) dated September 24, 2014 for the 12/31/2009 cost reporting period. On March 23, 2015, the Provider filed an individual appeal request with the following 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 Payment – Medicaid Eligible Days."

The Provider withdrew the Medicaid Eligible Days Issue.

On March 25, 2015, the Board received a request to directly add the Systemic Errors issue to a group appeal; 14-2308GC.

There is one issue that remains pending in the appeal: SSI Provider Specific.

Board's Decision

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

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

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was transferred to a group 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 a group appeal.

Because the Systemic Errors issue was directly added to a group appeal, the Board hereby dismisses this aspect of Issue No. 1.

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

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

Conclusion

The Board finds that it does not have jurisdiction over the last issue in the appeal, the SSI Provider Specific issue, in case no. 15-1947 for UHHS/Bedford Medical Center.

PRRB Case No. 15-1947 is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

Charlotte Benson for

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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RE: UH Reginal Hospitals
Provider No. 36-0075
FYE 12/31/2012
PRRB Case No. 15-2634

Dear Ms. Goron and Ms. Cummings,

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

Background

UH Regional Hospital, the Provider, appealed an Original Notice of Program Reimbursement (NPR) dated December 4, 2014 for the 12/31/2012 cost reporting period. On May 13, 2015, the Provider filed an individual appeal request with the following issues:

The Provider filed the appeal with the following 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 Payment – Medicaid Eligible Days."

The Provider withdrew the Medicaid Eligible Days Issue.

On May 15, 2015, the Board received a request to directly add the Systemic Errors issue to a group appeal, case no. 15-2628GC. There is one issue remaining in the appeal: SSI Provider Specific.

Board's Decision

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

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

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was transferred to a group 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 a group appeal.

Because the Systemic Errors issue was directly added to a group appeal, the Board hereby dismisses this aspect of Issue No. 1.

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

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

Conclusion

The Board finds that it does not have jurisdiction over the last issue in the appeal, the SSI Provider Specific issue, in case no. 15-2634 for UH Regional Hospitals.

PRRB Case No. 15-2634 is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

Charlotte F. Benson for

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

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

cc: Wilson Leong, FSS

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RE: UHHS/Bedford Medical Center
Provider No. 36-0115
FYE 12/31/2010
PRRB Case No. 15-2345

Dear Ms. Goron and Ms. Cummings,

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

Background

UHHS/Bedford Medical Center has appealed an Original Notice of Program Reimbursement (NPR) dated October 22, 2014 for the 12/31/2010 cost reporting period. On April 20, 2015, the Provider filed an individual appeal request with the following 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 Payment – Medicaid Eligible Days."

The Provider withdrew the Medicaid Eligible Days Issue.

On April 21, 2015, the Board received a request to directly add the Systemic Errors issue to a group appeal; 15-2334GC.

There is one issue remaining in the appeal: SSI Provider Specific.

Board's Decision

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

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

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was transferred to a group 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 a group appeal.

Because the Systemic Errors issue was directly added to a group appeal, the Board hereby dismisses this aspect of Issue No. 1.

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

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

Conclusion

The Board finds that it does not have jurisdiction over the last issue in the appeal, the SSI Provider Specific issue, in case no. 15-2345 for UHHS/Bedford Medical Center.

PRRB Case No. 15-2345 is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

Charlotte F Benson for

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

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

CERTIFIED MAIL

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

APR 17 2018

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

RE: QRS 2006 DSH Medicare Managed Care Part C Days Group (2)
CIRP Group, PRRB Case No. 13-1383G

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the Providers' March 19, 2018 request for expedited judicial review (EJR). The Board's decision with respect to jurisdiction and the EJR is set forth below.

Issue in Dispute

The issue in dispute in this case is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C.Cir. 2014). ("The Part C Days Issue")[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] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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

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

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]

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[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).
[10] 42 C.F.R. § 412.106(b)(4).

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[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 care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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

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

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[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.
[18] *Id.*

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[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 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 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

Jurisdictional Determination

The participants that comprise the group appeal within this EJR request have filed appeals involving fiscal year 2006.

For purposes of Board jurisdiction over a participant's appeal 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

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[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).

as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[23]

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 participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

Larkin Community Hospital (10-0181); FYE 12/31/2006 (Participant #14)

The Provider's revised NPR which was issued March 1, 2013 is the subject of this Provider's appeal. The Medicare Contractor agreed to reopen the cost report to revise Medicaid Utilization Percentage and issued a revised NPR. The Provider identified audit adjustment #5 which adjusted allowable DSH. Since the Part C days issue that is the subject of this group appeal was not adjusted in the revised NPR, the Board does not have jurisdiction over the Provider's appeal pursuant to 42 C.F.R. § 405.1889. This regulation states that any matter not specifically revised may not be considered in any appeal of the revised determination. The Board hereby dismisses the Provider from the appeal and since jurisdiction is a prerequisite to granting EJR, the Provider's request for EJR is denied.

Remaining Participants

The Board has determined that the remaining participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction or had a specific adjustment to the SSI fraction, self-disallowed, 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 Providers' appeals were timely filed and the estimated amount in controversy exceeds $50,000, as required for a group appeal.[25] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request covers fiscal year 2006, 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

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[23] 108 S.Ct. 1255 (1988).
[24] See 42 C.F.R. § 405.1889(b)(1).
[25] *See* 42 C.F.R. § 405.1837.

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 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 case number 13-1383GC.

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Pam VanArsdale, National Government Services, Inc. (Certified w/Schedule of Providers)
Wilson Leong, Esq., CPA, Federal Specialized Services (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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APR 17 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**

14-3173GC CHI 2011 DSH SSI Fraction Denominator/Part C Days CIRP Group
14-3174GC CHI 2011 DSH Medicaid Fraction Medicare Advantage Days CIRP Group

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 23, 2018 request for expedited judicial review (EJR) (received March 26, 2018). 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]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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[1] Providers' EJR Request at 3.
[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)(l); 42 C.F.R. § 412.106.

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

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]

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[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).
[10] 42 C.F.R. § 412.106(b)(4).

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[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 care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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

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

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[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.
[18] *Id.*

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[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' 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.[21] 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."[22] 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

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

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 2011.

For purposes of Board jurisdiction 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.[23]

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[24] 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 fiscal year 2011 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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[23] *See* 42 C.F.R. § 405.1835 (2008).
[24] *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 these group appeals are entitled to a hearing before the Board;

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

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

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

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Mounir Kamal, Novitas Solutions (Certified Mail w/Schedules of Providers)
Wilson Leong, FSS (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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APR 17 2018

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RE: **Expedited Judicial Review Determination**

Advocate Health Care 2007 DSH Medicare/Medicaid Part C Days CIRP Group
PRRB Case No. 13-2079GC

Community HCS 2010 Medicare/Medicaid Medicare Advantage Days CIRP Group
PRRB Case No. 13-3758GC

McLaren Health Care 2010 DSH Medicare/Medicaid Part C Days CIRP Group
PRRB Case No. 14-3908GC

Indiana University Health 2011 DSH Medicare/Medicaid Part C Days CIRP Group
PRRB Case No. 14-4310GC

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' April 11, 2018 request for expedited judicial review (EJR) (received April 12, 2018). The Board's determination is set forth below.

Issue

The issue for which EJR has been requested is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

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

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[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)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] "SSI" stands for "Supplemental Security Income."
[10] 42 C.F.R. § 412.106(b)(2)-(3).
[11] 42 C.F.R. § 412.106(b)(4).

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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.

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[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[18] 69 Fed. Reg. at 49,099.
[19] *Id.*
[20] 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).

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

Providers' Request for EJR

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

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

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

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

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[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] EJR Request at 8.
[23] *Id.* at 2.
[24] *Id.*
[25] *Id.*
[26] *Id.* at 7

Decision of the Board

Board's Authority

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

Jurisdictional Requirements

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the providers requesting EJR. Pursuant to the pertinent regulations governing Board jurisdiction, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[27]

In three of the groups included in this EJR request, the Providers filed appeals of their original notices of program reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2010 and 2011. Case number 13-2079GC includes Providers appealing from revised NPRs for the settled cost reporting period ending in 2007.

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

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

For 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 participants appealing from revised NPR appeals included within this EJR request were issued after August 21, 2008.

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[27] The regulations governing Board jurisdiction begin at 42 C.F.R. § 405.1835. For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[28] 108 S.Ct. 1255 (1988).
[29] See 42 C.F.R. § 405.1889(b)(1).

Jurisdiction

The Board finds that the Providers involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, have had a specific adjustment to the SSI fraction, or have properly protested/self-disallowed the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the Providers' documentation shows that the estimated amount in controversy for the group appeals exceed $50,000 and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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

The Providers within this EJR request filed appeals covering calendar years 2007, 2010 and 2011, thus the cost reporting periods fall squarely within the time frame that covers the Secretary's final rule being challenged.[30] In addition, the Board recognizes that the D.C. Circuit vacated the regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed,* No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). In addition, within its July 25, 2017 decision in *Allina Health Services v. Price*, the D.C. Circuit Court agreed with the Board's determination to grant EJR for the identical issue involved in the instant EJR request.[31]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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

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

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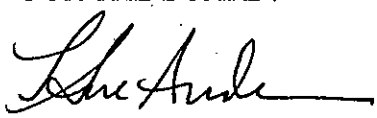
FOR THE BOARD:



L. Sue Andersen, Esq.
Chairperson

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

Certified w/ Schedules of Providers

cc: Elizabeth Elias, Hall Render
Danene Hartley, National Government Services
Byron Lamprecht, Wisconsin Physicians Service
Wilson Leong, Esq., CPA, Federal Specialized Services

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APR 17 2018

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RE: EJR Determination

15-0198GC Anderson 2011 DSH Medicare/Medicaid Medicare Advantage Days Group
15-2407GC Anderson 2012 DSH Medicare/Medicaid Medicare Advantage Days Group

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' April 11, 2018, requests for expedited judicial review (EJR) (received April 12, 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 CMS unlawfully treats days for which Medicare Part A did not make payment, namely Medicare Advantage days which are paid under Medicare Part C, as days for which patients are entitled to benefits under Medicare Part A for purposes of calculating the Medicare disproportionate share ("DSH") payment.[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]

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

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 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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[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)(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 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.[21]

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."[22] 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.

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

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 2011and 2012.

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.[23]

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[24] 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 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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[23] *See* 42 C.F.R. § 405.1835 (2008).
[24] *See* 42 C.F.R. § 405.1837.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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
Robert A. Everts, Esq.

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Mounir Kamal, Novitas (Certified Mail w/Schedules of Providers)
Wilson Leong, Esq., Federal Specialized Services (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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APR 17 2018

Certified Mail

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RE: **Expedited Judicial Review Determination**

14-1135G	K&S 2007 SSI Fraction Medicare Advantage Days Group
14-1136G	K&S 2007 Medicaid Fraction Medicare Advantage Days Group
17-0644G	K&S 2014 DSH Medicare Advantage Days (Pre-10/1/2013) Group

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 27, 2018, requests for expedited judicial review (EJR) (received March 28, 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 CMS unlawfully treats days for which Medicare Part A did not make payment, namely Medicare Advantage days which are paid under Medicare Part C, as days for which patients are entitled to benefits under Medicare Part A for purposes of calculating the Medicare disproportionate share ("DSH") payment.[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]

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

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

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[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)(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).

> 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]

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

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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.*

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 *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C*

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[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.

> *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. 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.[21]

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."[22] 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

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

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 2007 and 2014 (pre-10/31/2013).

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.*[23] 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]

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 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

[23] 108 S.Ct. 1255 (1988).
[24] *See* 42 C.F.R. § 405.1835 (2008).
[25] See 42 C.F.R. § 405.1889(b)(1) (2008).

properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals.[26] 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[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 and June 30, 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.

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

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[26] In case number 14-1136G, the Group Representative deleted #3 The Medical Center (provider number 18-0013), stating that the Provider's appeal had been dismissed on February 21, 2014. The same Provider (and fiscal year end) appeared in case number 14-1135G, the Board's records reflect that the Provider's appeal for the issue and fiscal year had been dismissed in the same correspondence and the Provider has been deleted from the Schedule of Providers.

[27] *See* 42 C.F.R. § 405.1837.

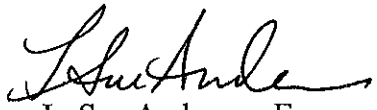
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

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

Board Members Participating:

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

FOR THE BOARD:



L. Sue Andersen, Esq.
Chairperson

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

cc: Judith Cummings, CGS Administrators (Certified Mail w/Schedules of Providers)
Wilson Leong, Esq., Federal Specialized Services (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Certified Mail APR 17 2018

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RE: **Expedited Judicial Review Determination**

- Premier Health Partners 2007 Medicare/Medicaid Part C Days Group Case No. 13-1580GC
- Franciscan Alliance 2007 DSH Medicare/Medicaid Medicare Advantage Days CIRP Group, Case No. 13-2048GC
- Community Health Network 2007 DSH Medicare Medicaid Part C Days CIRP Group, Case No. 13-2340GC
- Community Health Network 2008 Medicare/Medicaid Medicare Advantage Days CIRP Group, Case No. 13-2361GC
- Hall Render 2006 DSH Medicare/Medicaid Part C Days Group II Case No. 17-0491G

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' April 4, 2018 request for expedited judicial review (EJR) (received April 5, 2018). The Board's determination is set forth below.

Issue

The issue for which EJR has been requested is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

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[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)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] "SSI" stands for "Supplemental Security Income."
[10] 42 C.F.R. § 412.106(b)(2)-(3).

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

Medicare Advantage Program

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

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

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

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

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

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[11] 42 C.F.R. § 412.106(b)(4).
[12] of Health and Human Services
[13] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[14] *Id.*
[15] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-

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

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

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

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

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

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173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

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

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

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

[19] *Id.*

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

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

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

Providers' Request for EJR

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

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

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

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

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

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

Decision of the Board

Board's Authority

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

Jurisdictional Requirements

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the providers requesting EJR. Pursuant to the pertinent regulations governing Board jurisdiction, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[27]

All of the participants in Case Nos. 13-1580GC, 13-2048GC and 13-2340GC filed appeals of their original notices of program reimbursement ("NPRs") in which the Medicare contractor settled the cost reporting periods ending 12/31/2007. The participants in Case No. 13-2361GC appealed from original NPRs for the cost reporting period ending 12/31/2008. The participants in Case No. 17-0491G all appealed from revised NPRs ("RNPRs") in which the Medicare contractor settled the cost reporting period ending in 2006.

For purposes of Board jurisdiction over a cost reporting period that ends on or before December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed

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[25] *Id.*
[26] *Id.* at 7
[27] The regulations governing Board jurisdiction begin at 42 C.F.R. § 405.1835. For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[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.

Jurisdiction

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

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

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

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[28] 108 S.Ct. 1255 (1988).
[29] See 42 C.F.R. § 405.1889(b)(1).
[30] On April 10, 2018, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed objections to the EJR requests for PRRB Case Nos. 13-2048GC, 13-2340GC and 13-2361GC. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since the Board is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.
[31] As stated in the FY 2014 IPPS Final Rule, the Secretary "proposed to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP[,]" thus "sought public comments from interested parties . . ." following publication of the FY 2014 IPPS Proposed Rule, 78 Fed. Reg. 27578 (May 10, 2013). Ultimately, the Secretary finalized this DSH policy for FFY 2014 and subsequent years on August 19, 2013, in the FY 2014 IPPS Final Rule. *See* 78 Fed. Reg. 50496, 50615 (Aug. 19, 2013). The Provider appeals in the instant EJR request are all based upon FYs that began prior to 10/1/2013 and earlier.
[32] *See* 863 Fed. 3d 937 (D.C. Cir. 2017).

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in each group appeal, the Board hereby closes Case Nos. 13-1580GC, 13-2048GC, 13-2340GC, 13-2361GC and 17-0491G.

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Elizabeth Elias, Hall, Render, Killian, Heath & Lyman (Certified w/enclosures)
Judith E. Cummings, CGS Administrators (J-15) (Certified w/enclosures)
Danene Hartley, National Government Services (J-6) (Certified w/enclosures)
Byron Lamprecht, Wisconsin Physicians Service (J-8) (Certified w/enclosures)
Wilson Leong, Esq., CPA, Federal Specialized Services (w/enclosures)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

APR 17 2018

Certified Mail

Daniel J. Hettich, Esq.
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RE: **Expedited Judicial Review Determination**

14-4298GC Piedmont Healthcare 2012 SSI CIRP Group
15-1823GC Piedmont Healthcare 2012 Medicaid Fraction Part C Days CIRP

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 26, 2018, requests for expedited judicial review (EJR) (received March 27, 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 CMS unlawfully treats days for which Medicare Part A did not make payment, namely Medicare Advantage days which are paid under Medicare Part C, as days for which patients are entitled to benefits under Medicare Part A for purposes of calculating the Medicare disproportionate share ("DSH") payment.[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]

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

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

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[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)(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).

> 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]

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

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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.*

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 *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C*

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[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.

> *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. 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.[21]

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."[22] 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

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

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 year 2012.

For purposes of Board jurisdiction 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.[23]

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 participant revised NPR appeals included within this EJR request were issued after August 21, 2008. The Board concludes that it lacks jurisdiction over the following Providers:

Case No. 14-4298GC: # 2 Piedmont Fayetteville Hospital

Case No. 15-1823GC # 1 Piedmont Fayetteville Hospital
2 Piedmont Newman Hospital

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[23] *See* 42 C.F.R. § 405.1835 (2008).
[24] See 42 C.F.R. § 405.1889(b)(1) (2008).

The Providers above appealed revised NPRs that did not revised the matter at issue as required for Board jurisdiction under 42 C.F.R. § 405.1889(b) and hereby dismisses the Providers from their respective appeal. Since jurisdiction over a provider is a perquisite to granting a request for EJR, the Board hereby denies the Providers' request for EJR. *See* 42 C.F.R. § 405.1842(a).

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. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[25] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request involves the fiscal year 2012, 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.

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

[25] *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 remaining Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Cecile Huggins, Palmetto GBA (Certified Mail w/Schedules of Providers)
Wilson Leong, Esq., Federal Specialized Services (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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CERTIFIED MAIL

APR 17 2018

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

RE: QRS 2007 DSH Medicaid Fraction Medicare Managed Care Part C Days Group (2)[1]
CIRP Group, PRRB Case No. 13-2676G

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the Providers' March 19, 2018 request for expedited judicial review (EJR). The Board's decision with respect to jurisdiction and the EJR is set forth below.

Issue in Dispute

The issue in dispute in this case is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C.Cir. 2014). ("The Part C Days Issue")[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] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

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[1] The group name was updated pursuant to the Representative's November 15, 2013 bifurcation letter submitted in case no. 13-2679G.
[2] Providers' EJR request at 1.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

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

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

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

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

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

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

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

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[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] 42 C.F.R. § 412.106(b)(2)-(3).
[11] 42 C.F.R. § 412.106(b)(4).

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (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 (b)(2)(iii)(B) (the 2004 Rule). The Board is bound by the 2004 rule 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 no 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

Jurisdictional Determination

The participants that comprise the group appeal within this EJR request have filed appeals involving fiscal year 2007.

For purposes of Board jurisdiction over a participant's appeal 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

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[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).

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 participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

St. Alexius Medical Center (35-0002); FYE 12/31/2007 (Participant #36)

The Provider's revised NPR which was issued August 16, 2012 is the subject of this Provider's appeal. The Medicare Contractor agreed to reopen the cost report to review the hospital and rehab total Medicaid days including the additional days submitted and issued a revised NPR. The Provider identified audit adjustment #4 which adjusted Medicaid days to the state and provider listings and to adjust allowable DSH. Since the Part C days issue that is the subject of this group appeal was not adjusted in the revised NPR, the Board does not have jurisdiction over the Provider's appeal pursuant to 42 C.F.R. § 405.1889. This regulation states that any matter not specifically revised may not be considered in any appeal of the revised determination. The Board hereby dismisses the Provider from the appeal and since jurisdiction is a prerequisite to granting EJR, the Provider's request for EJR is denied.

Parkview Medical Center (06-0020); FYE 6/30/2007 (Participant #6)

The Representative supplied a copy of the Provider's transfer request of the ***SSI Percentage issue*** from its individual appeal (case no. 13-1452) to the QRS 2007 DSH SSI Percentage Group (2), case no. 13-2679G. The Managed Care and Dual Eligible Days issues were originally briefed in the individual appeal as sub-issues of the SSI Percentage (systemic) issue.

The only documentation submitted to corroborate the transfer to the subject Medicaid Fraction Part C days group is a copy of a November 15, 2013 letter from QRS, in which it requested the bifurcation of the SSI Fraction Part C days (and SSI Fraction Dual Eligible Days) issues from the SSI Percentage group, case no. 13-2679G. In that letter, the Representative advised that the Medicaid Fraction Part C days issue had already been established in a separate group to which the Board assigned case no. 13-2676G (and the Medicaid Fraction Dual Eligible days issue in case no. 13-2678G).[26]

On December 27, 2013, the Board granted the Representative's request for bifurcation and an SSI Fraction Part C days group was established, to which the Board assigned case no. 14-1173G (& the SSI Fraction Dual Eligible days was established in case no. 14-1174G). The Board finds that the information submitted, however, is not sufficient to document the transfer of the Medicaid Fraction Part C days issue from the individual appeal to this group. Neither the

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[24] 108 S.Ct. 1255 (1988).
[25] See 42 C.F.R. § 405.1889(b)(1).
[26] These groups were initially filed as "general" Managed Care Part C Days and "general" Dual Eligible Days groups – but the Representative clarified that both were specific to the Medicaid Fraction in its November 15, 2013 letter.

Representative's November 15, 2013 bifurcation request, nor the Board's December 27, 2013 letter granting the bifurcation of the SSI Fraction Part C days issue, substantiate the transfer of this Provider to the Medicaid Fraction Part C days group. Therefore, the Board dismisses Parkview Medical Center from case no. 13-2676G.[27]

St. Cloud Hospital (24-0036); FYE 6/30/2007 (participant #31)

The Representative did not supply any transfer documentation for this participant at Tab G. Based on the information listed on the Schedule of Providers, this participant appears to have the same fact pattern as Parkview Medical Center (#6) in that it transferred the SSI Percentage issue to case no. 13-2679G (the SSI Percentage group) from its individual appeal and alleges the bifurcation of that group proves the transfer to this Medicaid Fraction Part C days group. Therefore, the Board dismisses St. Cloud Hospital from case no. 13-2676G.

Previously Dismissed/Withdrawn Participants

The Board notes that the Schedule of Providers includes the following Providers which are no longer participants in the group:

#	Provider	Provider No.	FYE	Reason
18	Shands Jacksonville Medical Center	10-0001	6/30/2007	Withdrawn 5/17/2016
22	Leesburg Regional Medical Center	10-0004	6/30/2007	Withdrawn 4/29/2015

The Board previously denied the transfers of the following providers:

#	Provider	Provider No.	FYE	Denial Date
26	Union General Hospital	11-0051	4/30/2007	4/29/2015
37	Bismark Medical Center	35-0015	12/31/2007	4/7/2015

Therefore, the Board has removed these participants from the Schedule of Providers.

Remaining Participants

The Board has determined that the remaining participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction or had a specific adjustment to the SSI fraction, self-disallowed, 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 Providers' appeals were timely filed and the estimated amount in controversy exceeds $50,000, as required for a group appeal.[28] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

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[27] The evidence submitted on behalf of the Provider appears to confirm that the Provider was bifurcated from the SSI Percentage Group (case no. 13-2679G) where it was a valid participant, and was transferred to the SSI Fraction Part C days group (case no. 14-1173G).

[28] *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request covers 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 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 year and that the 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 case number 13-2676G.

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Pam VanArsdale, National Government Services, Inc. (Certified w/Schedule of Providers)
Wilson Leong, Esq., CPA, Federal Specialized Services (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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CERTIFIED MAIL

APR 1 7 2018

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

RE: HRS 2013 DSH SSI Percentage Optional Group, CN 15-3339G
Specifically the following participants with pending individual appeals:
North Oaks Medical Center, 19-0015, FYE 6/30/2013, CN 15-3336
Aspirus Wausau Hospital, 52-0030, FYE 6/30/2013, CN 16-1696
EMH Regional Medical Center, 36-0145, FYE 12/31/2013, CN 16-2341

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned group and the related individual appeals. We note that each of the Providers listed above appealed from a Notice of Program Reimbursement (NPR) for a 2013 cost reporting period. The NPRs, which were all issued after March 2015, were issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). The pertinent facts with regard to these appeals and the Board's determination are set forth below:

I. SSI Provider Specific Issue Only

The sole issue remaining in case numbers **15-3336, 16-1696 and 16-2341** is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. Each of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue directly into the optional group, case number 15-3339G.

The Providers are appealing two components of the SSI Percentage: 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.

With regard to 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—the Board finds it is duplicative of the Systemic Errors issue that was directly added to 15-3339G and this aspect is hereby dismissed by the Board.[1]

With regard to the second aspect of the SSI Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—the Board finds it lacks jurisdiction and dismisses this aspect of the issue. 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

[1] Providers' Individual Appeal Requests at Tab 3, Issue 1 and Appeal Request in 15-3339G.

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.

Since there are no other issues in these cases, the Board hereby closes case numbers **15-3336, 16-1696 and 16-2341** and removes them 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
Robert A. Evarts, Esq.

FOR THE BOARD

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

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

cc: Lorraine Frewert, Noridian Healthcare Solutions (J-E)
Mounir Kamal, Novitas Solutions, Inc. (J-H)
Danene Hartley, National Government Services (J-6)
Judith E. Cummings, CGS Administrators (J-15)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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APR 18 2018

RE: **18-0359; 17-1985GC; 17-0780**

CERTIFIED MAIL

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1800 Sutter Street, Suite 600
Concord, CA 94520-2546

RE: Petaluma Valley Hospital
Provider No.: 05-0136
FYE - 06/30/2006
PRRB Case Nos.: 17-0780 and 18-0359

St. Joseph HS 2006 Accuracy of CMS Developed SSI Ratio CIRP Group
Provider Nos.: Various
FYE - 12/31/2006
PRRB Case No.: 17-1985GC

Dear Ms. Giberti:

BACKGROUND/PERTINENT FACTS:

CASE NUMBER 18-0359 - Realignment of SSI% based on a REVISED Notice of Program Reimbursement ("NPR") dated 6/29/17:

By letter dated December 18, 2017, Toyon Associates, Inc. ("Toyon") filed a Request for Hearing in the matter of Petaluma Valley Hospital, Provider No.: 05-0136, Fiscal Year End ("FYE") - 06/30/2006. The Board acknowledged receipt of the appeal request and assigned case number 18-0359. It is noted that the appeal request for case number 18-0359 is based on a *Revised* Notice of Program dated June 29, 2017. The sole issue identified in the hearing request at Tab #3 is Medicare Disproportionate Share Hospital ("DSH") Payments - Accuracy of CMS Developed SSI Ratio. The Form A - Request for Hearing states that the Provider is commonly owned or controlled by Providence St. Joseph Health. (The Board notes that another appeal for the subject Provider's FYE 06/30/2006, case number 17-0780, had already been closed on September 11, 2017.)

In the letter accompanying the Form A, Toyon states, "Other related providers either have or will have appealed many of the same issues as set forth in this appeal. Appropriate group appeal requests will be filed for all common issues."

CASE NUMBER 17-0780 – "New" 2006 SSI% from a RNPR dated 7/14/16:

By letter dated January 9, 2017, Toyon had previously filed a Request for Hearing in the matter of Petaluma Valley Hospital, Provider No.: 05-0136, FYE - 06/30/2006. The Board acknowledged receipt of the appeal request and assigned case number 17-0780. The appeal was based on a *Revised* Notice of Program dated July 14, 2016. There were two (2) issues identified that the Provider was disputing in the hearing request. Issue #2 at Tab #3 is stated as the Medicare Disproportionate Share Hospital ("DSH") Payments - Accuracy of CMS Developed SSI Ratio. The Form A - Request for Hearing states that the Provider is commonly owned or controlled by St. Joseph Health System.

By letter dated September 1, 2017, Toyon transferred both issues in case number 17-0780 to Common Issue Related Party ("CIRP") group appeals and advised that the individual appeal was fully resolved with the transfer of the two issues. Issue #2 involving the Medicare DSH Payments-Accuracy of CMS Developed SSI Ratio was transferred to CIRP group case number 17-1985GC.

Upon the transfer of the issues, case number 17-0780 was closed on September 11, 2017.

CASE NUMBER 17-1985GC:

By letter dated August 2, 2017, Toyon filed a Form B - Group Appeal Request to establish a CIRP group. The Proposed Group Name was St. Joseph HS 2006 Accuracy of CMS Developed SSI Ratio CIRP Group. The Board acknowledged receipt of the CIRP group and assigned case number 17-1985GC.

As noted above, Toyon filed a Form D on September 1, 2017, transferring said issue from the appeal of Petaluma Valley Hospital, CN: 17-0780, to the subject CIRP group.

REFERENCES:

Board Rule 12.2 states, in part:

> Commonly owned or controlled Providers with the same issue in cost reporting periods ending in the same calendar year must file a mandatory group appeal if the combined amount in controversy is $50,000 or more.

CONCLUSION/BOARD DETERMINATION:

Pursuant to the Board's Rules, the Board will consolidate all appeals from final determinations for the same cost reporting period into the existing case number. In addition, a Provider may not appeal an issue from a final determination in more than one appeal. (See Board Rules 4.5 and 6.2.)

Because the issue stated above was previously transferred and is currently being pursued by the subject Provider in a group appeal, case number 17-1985GC, the request to continue to pursue the subject issue in the newly formed individual appeal, case number 18-0359, is hereby **denied**. The same issue cannot be pending in multiple appeals for the same Provider for the same fiscal year end. Therefore, the Board is incorporating the Provider's appeal of its Revised NPR dated June 29, 2017 into the existing CIRP group for the subject issue, case number 17-1985GC.

The Board hereby **closes** case number 18-0359 since the Medicare Disproportionate Share Hospital ("DSH") Payments - Accuracy of CMS Developed SSI Ratio issue is the sole issue being disputed and has now been transferred to CIRP group case number 17-1985GC.

Please note that when submitting the Schedule of Providers in CIRP group case number 17-1985GC, you must list the multiple final determinations in dispute for Petaluma Valley Hospital, Provider No. 05-0136, FYE - 06/30/2006 and provide the supporting jurisdictional documents for each final determination in dispute. (See Board Rules 20 and 21.A.)

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

cc: Lorraine Frewert
Appeals Coordinator - Jurisdiction E
Noridian Healthcare Solutions
P.O. Box 6782
Fargo, ND 58108-6782

Wilson C. Leong, Esq., CPA
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1701 S. Racine Avenue
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

APR 19 2018

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

RE: HRS 2012 DSH SSI Percentage Optional Group, CN 15-0479G
Specifically the following participants with pending individual appeals:
Yavapai Regional Medical Center, 03-0118, FYE 12/31/2012, CN 15-0852
East Valley Hospital Medical Center, 05-0205, FYE 12/31/2012, CN 15-3338
Lodi Memorial Hospital, 05-0336, FYE 12/31/2012, CN 15-0303
Sonoma Valley Hospital, 05-0090, FYE 6/30/2012, CN 15-0607
EMH Regional Medical Center, 36-0145, FYE 12/31/2012, CN 15-0641
Hardin Memorial Hospital, 18-0012, FYE 6/30/2012, CN 14-3548
North Oaks Medical Center, 19-0015, FYE 6/30/2012, CN 15-0611
Lima Memorial Hospital, 36-0009, FYE 12/31/2012, CN 15-0828
Robinson Memorial Hospital, 36-0078, FYE 12/31/2012, CN 15-2302
Roxborough Memorial Hospital, 39-0304, FYE 2/21/2012, CN 15-2729
Aspirus Wausau Hospital, 52-0030, FYE 6/30/2012, CN 15-1949

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned group and the related individual appeals. We note that each of the Providers listed above appealed from a Notice of Program Reimbursement (NPR) for a 2012 cost reporting period. The NPRs, which were all issued after June 2014, were issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). The pertinent facts with regard to these appeals and the Board's determination are set forth below:

Although the Medicare Contractor only challenged jurisdiction over this issue in two of the cases (15-0828 and 15-0303), the Board finds that it does not have jurisdiction over the SSI Provider Specific issue for any of the above-referenced Providers. The jurisdictional analysis for the SSI Provider Specific issue has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

I. SSI Provider Specific Issue Only

The sole issue remaining in case numbers **15-0303, 15-0607, 15-0611, 15-0641, 15-0828, 15-1949, 15-2729 and 15-3338** is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. Each of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue directly into the optional group, case number 15-0479G.

The Providers are appealing two components of the SSI Percentage: 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.

With regard to 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—the Board finds it is duplicative of the Systemic Errors issue that was directly added to 15-0479G and this aspect is hereby dismissed by the Board.[1]

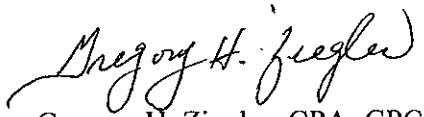
With regard to the second aspect of the SSI Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—the Board finds it lacks jurisdiction and dismisses this aspect of the issue. Under 42 C.F.R. § 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.

Since there are no other issues in these cases, the Board hereby closes case numbers **15-0303, 15-0607, 15-0611, 15-0641, 15-0828, 15-1949, 15-2729 and 15-3338** and removes them 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.

Because there is a remaining issue in case nos. 15-0852, 15-2302 and 14-3548 the cases will remain open. The Parties will receive a Notice of Hearing scheduling the cases for a hearing date under separate cover in the future.

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

FOR THE BOARD



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

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

cc: John Bloom, Noridian Healthcare Solutions, LLC (J-F)
Lorraine Frewert, Noridian Healthcare Solutions (J-E)
Judith E. Cummings, CGS Administrators (J-15)
Mounir Kamal, Novitas Solutions, Inc. (J-H)
Danene Hartley, National Government Services (J-6)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

[1] Providers' Individual Appeal Requests at Tab 3, Issue 1 and Appeal Request in 15-3339G.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Certified Mail

APR 2 0 2018

Daniel J. Hettich
King & Spalding, LLP
1700 Pennsylvania Avenue, NW
Suite 200
Washington, DC 20006 4706

RE: **Expedited Judicial Review Determination**
K & S 2009 DSH Medicaid Fraction Medicare Advantage Days Group, Case No. 14-3377G
K & S 2009 DSH SSI Fraction Medicare Advantage Days Group, Case No. 14-3378G
K & S 2010 DSH SSI Fraction Medicare Advantage Days Group, Case No. 15-0206G
K & S 2010 DSH Medicaid Fraction Medicare Advantage Days Group, Case No. 15-0208G
K & S 2011 DSH Medicaid Fraction Medicare Advantage Days Group, Case No. 15-0342G
K & S 2011 DSH SSI Fraction Medicare Advantage Days Group, Case No. 15-0343G
K & S 2012 DSH SSI Fraction Medicare Advantage Days Group, Case No. 15-2267G
K & S 2012 DSH Medicaid Fraction Medicare Advantage Days Group, Case No. 15-2269G
K&S 2013 DSH Medicaid Fraction Med. Adv. Days (Pre-2013) Group, Case No. 15-3365G
K&S 2013 DSH SSI Fraction Med. Adv. Days (Pre-10/1/2013) Group, Case No. 15-3369G
K & S 2011 DSH Medicaid Fraction Medicare Advantage Days Group II, Case No. 16-2406G
K & S 2011 DSH SSI Fraction Medicare Advantage Days Group II, Case No. 16-2407G

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) issued an expedited judicial review (EJR) determination for the above-referenced appeals on March 20, 2018. It has recently come to our attention that the Schedules of Providers for the subject group appeals were not included as an enclosure to the determination. Therefore, we are now sending copies of the Schedules of Providers. We apologize for any confusion this oversight may have caused.

The Board has also received your April 18, 2018 request for clarification of the EJR determination with regard to Dubois Regional Medical Center in case numbers 15-0206G and 15-0208G. In the Board's March 20, 2018 EJR determination, the Board found that it lacks jurisdiction over the revised NPR appeal for this Provider and dismissed if from both cases. The original NPR appeal for this Provider remains in the cases.

Sincerely,

Christine M. Blowers, Director
Division of Systems & Case Management

Enclosures: Schedules of Providers

cc: **(Certified Mail w/Schedules of Providers)**
Judith E. Cummings, CGS Administrators (J-15)
Bruce Snyder, Novitas Solutions, Inc. (J-L)
Geoff Pike, First Coast Service Options, Inc. (J-N)
Wilson Leong, Esq.,CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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APR 2 0 2018

Certified Mail

Stephanie A. Webster, Esq.
Akin Gump Straus Hauer & Feld LLP
1333 New Hampshire Avenue, NW
Washington, DC 20036-1564

RE: **Expedited Judicial Review Determination**

14-2658GC	Geisinger 2010 SSI Fraction Part C Days CIRP
14-2670GC	Geisinger 2010 Medicaid Fraction Part C Days CIRP
16-0404G	Duane Morris 2004 Part C Days group discharges after 09/30/2004
16-0412GC	Catholic Health System NY Post 9/30/2004 - 2005 Part C Days CIRP Group
16-0495GC	Geisinger Post-9/30/2004-2006 Part C Days CIRP Group
16-1408C	Carepoint 2013 DSH SSI Part C Days CIRP Group
16-1410GC	Carepoint 2013 DSH On/Before 9/30/2013 Medicaid Fraction Part C Days CIRP Group
16-1478G	McKay 2006-2007 Medicaid Fraction Part C Days Group II
16-1480G	McKay 2006-2007 SSI Part C Days Group II
17-0317GC	Carepoint 2008 SSI Part C Days CIRP Group
17-0318GC	Carepoint 2008 Medicaid Fraction Part C Days CIRP Group
17-0406GC	Carepoint 2007 SSI Part C Days CIRP Group
17-0407GC	Carepoint 2007 Medicaid Fraction Part C Days CIRP Group
18-1085GC	CarePoint 2009 Part C Days CIRP Group
18-1089GC	CarePoint Health 2010 Part C Days CIRP Group
18-1091GC	CarePoint 2011 Part C Days CIRP Group

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 29, 2018 request for expedited judicial review (EJR) (received March 30, 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

[1] "SSI" is the acronym for "Supplemental Security Income."

> whether, if not regarded as 'entitled to benefits under Part A,' they should instead be included in the Medicaid fraction" of the DSH[2] adjustment.[3]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

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[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services.

> Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[14]

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

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

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

> . . . 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* (*Allina I*),[22] vacated the FFY 2005 IPPS rule. However, the Secretary has not acquiesced to that decision. 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 point out that prior to the 2004 rulemaking, in which the Secretary attempted to adopt a new policy to begin counting Part C days in the Medicare Part A/SSI fraction, the Secretary treated Part C patients as not entitled to benefits under Part A, rather they should be

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[20] *Id.*
[21] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] 2017 WL 3137976 (D.C. Cir. July 25, 2017).

included in the Medicaid fraction of the DSH adjustment.[24] 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."[25] 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."[26] 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."[27]

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.[28] 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.[29]

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.[30] 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.[31]

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 years 2004-2011 and 2013.

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

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[24] Providers' EJR Request at 4 citing to Allina 746 F.3d at 1105.
[25] 68 Fed Reg. at 27,208.
[26] *Id.*
[27] *Id.*
[28] 69 Fed Reg. 49,099 (Aug. 11, 2004).
[29] Providers' EJR Request at 5-6.
[30] *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.").
[31] *Id.*

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.*[32] 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.[33]

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.[34] 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 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 (which included Part C days), 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[35] and $10,000 for the individual appeals. 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 Decision Regarding the EJR Request

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2004-2011 and 2013.

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.*[36] 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.[37]

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[32] 108 S.Ct. 1255 (1988).
[33] *See* 42 C.F.R. § 405.1835 (2008).
[34] See 42 C.F.R. § 405.1889(b)(1) (2008).
[35] *See* 42 C.F.R. § 405.1837.
[36] 108 S.Ct. 1255 (1988).
[37] *See* 42 C.F.R. § 405.1835 (2008).

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.[38] 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 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 2006-2011, 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. [39]

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;

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

[39] On February 27, 2018 one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in a number of cases identified in the EJR request. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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

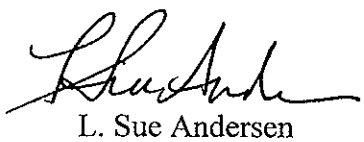
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

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 remaining Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in the cases, the Board hereby closes the appeals.

Board Members Participating:

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

FOR THE BOARD:



L. Sue Andersen
Chairperson

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

cc: Bruce Snyder, Novitas (Certified Mail w/Schedules of Providers)
Pam VanArsdale, NGS (Certified Mail w/Schedules of Providers)
Laurie Polson, Palmetto GBA c/o 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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APR 2 4 2018

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Mounir Kamal, Director JH Provider Audit & Reimburse.
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Pittsburgh, PA 15219

RE: Jurisdictional Decision
Provider: Memorial Hermann Hospital System
Case Number: 04-1946
FYE: 06/30/1999

Dear Mr. Layne and Mr. Kamal:

Background

Memorial Hermann Hospital System ("Provider") is appealing the amount of Medicare reimbursement determined by its Medicare Contractor in a Notice of Program Reimbursement ("NPR") dated February 6, 2004. The Provider filed a timely appeal from the NPR on July 30, 2004. The appeal request contained the following seven issues:

1) Issue No. 1 regarding Sub-provider I days and discharges,
2) Issue No. 2 regarding Sub-provider II days and discharges,
3) Issue No. 3 regarding GME and IME FTEs, including IME reimbursement,
4) Issue No. 4 regarding Accuracy of DSH SSI Percentage Data (transferred to Case No. 09-0735GC)
5) Issue No. 5 regarding capital reimbursement (DSH and IME)
6) Issue No. 6 regarding Bad Debts, and
7) Issue No. 7 regarding Protested Items.

The Provider added the following issues to this case:

8) Blending of costs/fees – OPPS not implemented (transferred to Case No. 06-1076G),

9) Home Office Interest Expense,[1]
10) DSH SSI percentage realignment to cost reporting period,

The Provider notified the Board on January 23, 2018 via e-mail that "[t]he only remaining issue relates to whether nursery bassinets should be counted as available beds for GME / IME reimbursement: the same matter subject to a jurisdictional challenge for the prior cost report year, Case No. 04-0497...". The Medicare Contractor filed a jurisdictional challenge on February 6, 2018 alleging that the Board does not have jurisdiction over this last remaining Issue No. 3A addressing whether or not Level II Nursery bassinet /NICU beds were properly counted for indirect medical education ("IME") reimbursement.

The Medicare Contractor's Contentions

The Medicare Contractor contends it did not adjust to categorize the Provider's Level II nursery bassinets as NICU beds, and that the Provider filed its cost report with these Level II nursery bassinets included as part of its NICU beds.[2] The Medicare Contractor states that audit adjustment no. 15 increased Adult and Pediatric bed days by 2,759, and increased NICU bed days by 30, for a total increase of 2,789 bed days.[3] However, the Medicare Contractor asserts that it did not adjust Level Nursery NICU bassinets and the Board lacks jurisdiction because the Provider has not preserved its right to claim dissatisfaction with the Medicare reimbursement for this issue under 42 C.F.R. §405.1835(a)(1).

The Provider's Contentions

The Provider describes this issue in its Final Position Paper, stating that available beds should be decreased to 688.15 because the Medicare Contractor incorrectly categorized Level II nursery bassinets as Neonatal Intensive Care Unit ("NICU") beds. The Provider reported an available bed count on its as-filed cost report (Worksheet E, Part A, Line 3) as 729.69.[4] The Provider's position is that Medicare regulations specifically exclude "beds or bassinets in the healthy newborn nursery" from the available bed count pursuant to 42 C.F.R. § 412.105(b),[5] and the Provider now seeks to have the available beds reduced.

The Provider filed a response to the Medicare Contractor's jurisdictional challenge on March 7, 2018. The Provider contends the Medicare Contractor must ensure that the Provider's cost report is in conformity with the Medicare principles of payment, and must determine the proper payment due to the

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[1] The Provider requested an appeal for a Revised Notice of Program Reimbursement ("RNPR") dated August 4, 2006. This RNPR appeal request contained one issue regarding Home Office Interest Expense, and the Board incorporated this appeal request/issue into Case No. 04-1946 on February 26, 2007.
[2] Medicare Contractor's Jurisdictional Challenge (Feb. 2, 2018) at 2.
[3] *Id.*
[4] Provider's Final Position Paper (Oct. 31, 2017), Exhibit 3 "As-Filed Cost Report" at 224.
[5] Provider's Final Position Paper (Oct. 31, 2017) at 3-4.

Provider, including overpayment made or underpayment due.[6] The Provider states the bed count it provided on the cost report was "subject to a clerical error," and it now seeks proper reimbursement and a corrected bed count.[7] The Provider urges the Board to take jurisdiction over this issue.

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841 (2003), 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 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 Hospital v. Sebelius,* 134 F. Supp.3d 238 (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."[8] The Court found the Board's ruling is "based upon a permissible construction of the statute," and therefore affirmed the Board's decision.[9]

In this instant case, the Provider failed to properly claim IME reimbursement costs, specifically the Level II Nursery bassinets /NICU Beds on its as-filed cost 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."[10]

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[6] Provider's Response to MAC's Jurisdictional Challenge (Mar. 6, 2018) at 3.
[7] Provider's Response to MAC's Jurisdictional Challenge (Mar. 6, 2018) at 4.
[8] *Id.* at 4 (citation omitted).
[9] *Id.*at 5.
[10] *Bethesda,* 485 U.S. 399 (1988) at 404-405.

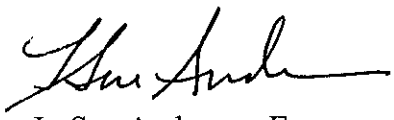
Using the rationale in the *St. Vincent* case (which addresses the *Bethesda* case), the Board finds the errors and omissions for Issue No. 3A, Level II Nursery bassinets /NICU Beds raised in the appeal were due solely to the Provider's negligence in understanding the Medicare regulations governing the 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).[11] While the Provider did file a jurisdictionally valid appeal for dissatisfaction with issues other than this challenged 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 Issue No. 3A as it addresses items and services not claimed, or not properly claimed. Therefore, the Board dismisses Issue No. 3A, Level II Nursery bassinet/ NICU Beds 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 Ziegler, CPA, CPC-A

FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

cc: Wilson Leong, Esq., FSS

[11] *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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APR 2 4 2018

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Union Trust Bldg.
501 Grant Street, Suite 600
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RE: Jurisdictional Decision
Provider: Houston Methodist San Jacinto Hospital
Case Number: 14-2618
FYE: 12/31/2009

Dear Ms. Chi and Mr. Kamal:

Background

Houston Methodist San Jacinto Hospital, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. The Provider filed the request for appeal on February 24, 2014 regarding a Notice of Program Reimbursement dated August 27, 2013. There were eight issues stated in the Model Form A – Individual Appeal Request:

1) Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)(hereinafter "DSH SSI Percentage Realignment),

2) Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)(hereinafter "DSH SSI Percentage Provider Specific),

3) Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI")(Systemic Errors)(hereinafter "DSH SSI Percentage Systemic Errors),

4) Disproportionate Share Hospital Payment – Medicaid Eligible Days,

5) Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days,

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

7) Whether Capital IME and DSH were calculated correctly, and

8) Medicaid Rehab eligible days in the LIP calculation.

The Provider has withdrawn Issue No. 4 (Medicaid Eligible Days)[1] and Issue No. 8 (Rehab Medicaid Eligible Days/LIP Adjustment)[2]. The Provider has filed the following Requests to Transfer Issue to a Group Appeal:

1) Issue No. 3 to Case No. 14-4359GC,

2) Issue No. 5 (bifurcated) to Case No. 14-4110GC and 14-4361GC, and

3) Issue Nos. 6 to Case No. 14-4362GC,

Issue Nos. 1, 2, and 7 remain in the appeal. The Medicare Contractor has filed Jurisdictional Challenges (Aug. 5, 2015 and Jan. 25, 2018) regarding Issue Nos. 1 and 2.

Medicare Contractor's Position

The Medicare Contractor filed a Jurisdictional Challenge (Aug. 5, 2015) alleging Issue No. 1 (DSH SSI Percentage Realignment), Issue no. 2 (DSH SSI Percentage Provider Specific), and Issue No. 3 (DSH SSI Percentage Systemic Errors) are the same issue and two of the issues should be dismissed. The Medicare Contractor alleges that duplicative issues are prohibited, and all three of these issues refer to MedPar data. The Medicare Contractor requests that the Board dismiss Issue Nos. 1 and 2 as it does not have jurisdiction over these issues.

The Medicare Contractor filed a Jurisdictional Challenge (Jan. 25, 2018) which continues to maintain that Issue Nos. 1 and 2 should be dismissed. This Challenge also states there is an additional jurisdictional impediment related to Issue No. 1 (DSH SSI Percentage Realignment) because the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election and not a final determination made by the Medicare Contractor. Because a provider's right to a hearing derives

[1] Via letter dated September 23, 2016.
[2] Via letter dated July 9, 2014.

from the determination of the amount of total reimbursement due the provider, the Medicare Contractor's position is that appeal of this issue is premature as there has been no request from the Provider to have its SSI percentage realigned.

The Provider's Position

The Provider filed a Jurisdictional Response (Sept. 1, 2015). The Provider claims Issue Nos. 1 (DSH SSI Percentage Realignment), 2 (DSH SSI Percentage Provider Specific), and 3 (DSH SSI Percentage Systemic Errors) are separate and distinct issues and the Board should find it has jurisdiction over all three issues. With regards to Issue No. 1, the Provider states it is entitled to receive MedPar data and realign its fiscal year end. With regards to Issue No. 2, the Provider states it seeks MedPar data to reconcile its records and verify no patients were omitted. The Provider claims Issue No. 3 addresses more in-depth aspects of the MedPar data as well as Medicare Part C days.

The Provider filed a second Jurisdictional Response (Feb. 16, 2018) in which it restates that Issue Nos. 1 and 2 are different components of the SSI issue. The Provider contends that it is entitled to appeal these issues because the Medicare Contractor adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments it received.

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. "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.[3]

[3] 42 C.F.R. § 405.1835(a) (emphasis added).

PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal. Pursuant to 42 C.F.R. 412.106(b)(3), a Provider may request that CMS use its cost reporting period instead of the Federal fiscal year in calculating the SSI percentage of the DSH payment calculation. It must make such a request in writing to its Medicare Contractor.

Issue No. 1 contends that the "SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation."[4] The Provider also states it "is seeking SSI data from CMS in order to reconcile its records with CMS data..." and that the Provider "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[5] The Provider cites to Adjustment Nos. 13, 14 and 40 regarding this issue, and states an estimated amount in controversy of $22,743.

Identically, Issue No. 2 contends that the "SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation."[6] The Provider also claims it "is seeking SSI data from CMS in order to reconcile its records with CMS data..."[7] The Provider cites to Adjustment Nos. 13, 14 and 40, and states an estimated amount in controversy of $22,744.

The Provider describes Issue No. 3 as the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the [Medicare Contractor] to settle their Cost Report was incorrectly computed" for the following reasons:

1) Availability of data from MedPAR[8] and SSA[9] Records,

2) Paid Days versus Eligible Days,

3) Not in Agreement with Provider's Records,

4) Fundamental Problems in the SSI Percentage Calculation,

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[4] Provider's Model Form A – Individual Appeal Request (Feb. 21, 2014), Tab 3 at 1.
[5] *Id.*
[6] Provider's Model Form A – Individual Appeal Request (Feb. 21, 2014), Tab 3 at 2.
[7] *Id.*
[8] Medicare Provider Analysis and Review Files
[9] Social Security Administration

5) Covered Days versus Total Days,

6) Non-Covered Days,

7) CMS Ruling 1498-R and the Ruling's Matching Methodology, and

8) Failure to Adhere to Required Notice and Comment Rulemaking Procedures.[10]

The Board finds it has jurisdiction over the portion of Issue No. 1 (DSH SSI Percentage Realignment) and Issue No. 2 (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. 40), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the inaccurate data portion of both Issue Nos. 1 and 2 is duplicative of Issue No. 3, the DSH SSI Percentage Accurate Data issue which was transferred to Case No. 14-4359GC. The basis of all three 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 Nos. 1 and 2 are dismissed from the appeal because they are duplicative of Issue No. 3, and the issue now resides in Case No. 14-4359GC.

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 that aspect of Issue No. 1, the DSH SSI Percentage Realignment issue, and it is dismissed from the appeal.

In conclusion, Issue Nos. 1 and 2 are dismissed from the appeal for the reasons stated above. The appeal will remain open for resolution of Issue No. 7.

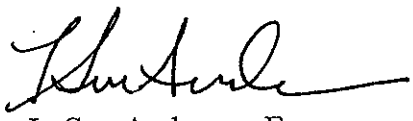
[10] Provider's Model Form A – Individual Appeal Request (Feb. 21, 2014), Tab 3 at 2-10.

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
Robert Evarts, Esq.

FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

cc: Wilson Leong, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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APR 2 7 2018

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Provider:	Lee Regional Medical Center
Provider No.:	49-0012
FYE:	06/30/2008
PRRB Case No.:	13-2601

Dear Mr. Ravindran and Ms. Huggins:

The Provider, Lee Regional Medical Center ("Lee Regional" or "Provider"), appealed the amount of its Medicare reimbursement calculated by the Medicare Contractor, Palmetto GBA ("Palmetto" or "Medicare Contractor"). The Provider Reimbursement Review Board ("Board") hereby determines that it lacks jurisdiction over the DSH/SSI (Provider Specific) issue. The Board further determines that it will grant jurisdiction over the Medicaid Eligible Days issue and will schedule that issue for a hearing under separate cover.

Background

Lee Regional timely appealed its Notice of Program Reimbursement ("NPR") for fiscal year 2008 to the Board on the basis of the following issues:

(1) DSH/SSI% (Provider Specific);
(2) DSH/SSI% (Systemic Errors);
(3) Medicaid Eligible ("ME") Days;
(4) SSI% Part C Days;
(5) ME Labor Room Days;
(6) SSI%/Dual Eligible ("DE") Days;
(7) Outlier Payments – Fixed Loss Threshold; and,
(8) Rural Floor Budget Neutrality Adjustment.[1]

Lee Regional described the two DSH SSI% issues as "[w]hether the Secretary properly calculated the Provider's [SSI%]" (Systemic Errors) and "[w]hether the [Medicare Contractor] used the correct [SSI%] in the [DSH] calculation" (Provider Specific).[2] In the description of its SSI% (Provider Specific) issue, Lee Regional writes, "[t]he Provider also hereby preserves its right to request under separate cover that CMS

[1] Lee Regional Individual Appeal Request at Tab 3, Aug. 6, 2013 ("Appeal Request").
[2] Appeal Request Tab 3 at 1.

recalculate the [SSI%] based upon the Provider's cost reporting period."[3] This is otherwise known as an SSI Realignment.

Lee Regional requested several transfers:

(1) DSH/SSI% (Systemic Errors) to Case No. 14-0404GC;
(2) SSI% Part C Days to Case No. 14-0409GC;
(3) Medicaid% Part C Days to Case No. 14-0411GC;
(4) ME Labor Room Days to Case No. 14-0405GC;
(5) Medicaid%/Dual Eligible ("DE") Days to Case No. 14-0408GC;
(6) Outlier Payments – Fixed Loss Threshold to Case No. 14-0399GC; and,
(7) Rural Floor Budget Neutrality Adjustment to Case No. 14-2528GC.[4]

Lee Regional filed its Alert 10 Response regarding ME Days on July 1, 2014.[5] Subsequently, the Medicare Contractor filed a Jurisdictional Challenge to the DSH/SSI% (Provider Specific) and ME Days issues.[6] The Provider then submitted its Jurisdictional Response.

Medicare Contractor's Contentions

DSH/SSI% (Provider Specific)

The Medicare Contractor contends that, regarding the SSI Realignment, "if a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its Medicare Contractor, a written request."[7] The Medicare Contractor states that Lee Regional did not make a written request for SSI Realignment; therefore, there is no final determination to establish jurisdiction as required under 42 C.F.R. § 405.1835.[8] The Medicare Contractor cites to the Board's decision in PRRB Case No. 13-2358 in which the Board denied the SSI Realignment issue as premature since the Provider never submitted a written request.[9]

ME Days

The Medicare Contractor claims that it did not review ME Days and no adjustment was made to ME Days.[10] In other words, all of the ME Days claimed on the as-filed cost report were allowed. The Medicare Contractor asserts that jurisdiction is rooted in an "identifiable adverse finding," which is missing in this issue.[11] The Medicare Contractor states that there was nothing that prevented the Provider from claiming the ME Days and does not need to put forward "new" ME Days following a finalized cost report.[12] The Medicare Contractor concludes that, since there was no adjustment for ME Days, there is no final determination as required for an appeal.[13]

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[3] *Id.*
[4] *See* Transfer Requests, Mar. 6, 2014.
[5] The Board issued Alert 10 to give providers the opportunity to supplement ME Days appeals with certain information, including a detailed description of the process that providers used to identify and accumulate ME Days that were reported on their cost reports.
[6] Medicare Contractor Jurisdictional Challenge, Jul. 21, 2014 ("Jurisdictional Challenge").
[7] *Id.* (citing 42 C.F.R. § 412.106).
[8] *Id.* at 1.
[9] Jurisdictional Challenge Ex. I-1.
[10] Jurisdictional Challenge at 2.
[11] *Id.*
[12] *See id.*
[13] *Id.*

The Medicare Contractor requests that the Board dismiss both issues and close the case.

Provider's Contentions

DSH/SSI% (Provider Specific)

The Provider argues that it is not only challenging the realignment of the SSI%, but also addressing various errors of omission and commission that do not fit into the "systemic errors" category.[14] Accordingly, the Provider states that DSH/SSI% (Provider Specific) is an appealable issue because the SSI% was adjusted and the Provider is dissatisfied with the amount of DSH payments it received for FY 2008.[15] The Provider claims it can submit data to prove its SSI% was understated; however, it is unable to do so until it receives data from CMS to specifically identify dually eligible patients that were not included in its SSI%.[16] The Provider maintains that it may choose to request SSI Realignment as well.

ME Days

The Provider contends that, although not necessary for Board jurisdiction, the Medicare Contractor specifically adjusted the Provider's DSH payments.[17] Therefore, the Provider asserts that the Board has jurisdiction over both the DSH/SSI% and DSH/ME Days issues. In addition, the Provider states that the documentation necessary to pursue DSH is often not available from the state in time to include all ME Days in the cost report. However, as the Medicare Contractor adjusted DSH, the Provider contends that the Board has jurisdiction over its ME Days.

Board Determination

DSH/SSI% (Provider Specific)

The DSH/SSI% (Provider Specific) issue contends that the Provider is dissatisfied because the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory Instructions." Specifically, the Provider disagrees with the Medicare Contractor's calculation of the SSI%. The DSH/SSI% (Systemic Errors) issue contends that the Secretary improperly included days in the SSI% and used an improper method in computing SSI%s.[18] The SSI% (Systemic Errors) issue was transferred to a group appeal. Board Rule 4.5 states that "[a] Provider may not appeal an issue from a final determination in more than one appeal."[19] The Board finds that the explanation of the SSI% issue is duplicative of the SSI% (Systemic Errors) issue. Here, the Provider contends that the SSI% applied to its cost report was incorrect in both the "Provider Specific" and "Systemic Errors" issues. The SSI% is computed by the Secretary and the Medicare Contractor is required to use that SSI% in the Provider's cost report. Under Board Rules, Lee Regional is barred from filing a duplicate SSI% issue.

The Provider also raises SSI Realignment. Under 42 C.F.R. § 412.106(b)(3), a provider may use its cost reporting period data instead of the federal fiscal year data in determining the SSI%. If a hospital decides to use its own cost reporting period, it must submit a written request to the Medicare Contractor. Without this request, the Medicare Contractor cannot issue a final determination. Furthermore, 42 C.F.R. § 412.106(b)(3) states that the provider must use that data from its cost reporting year; there is no appeal

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[14] Provider's Jurisdictional Response, Jul. 28, 2014.
[15] Jurisdictional Response at 3.
[16] *Id.* at 4.
[17] *Id.* Ex. I-2.
[18] The Provider, in its Appeal Request, separates this issue into 3 sections: the Provider claims that the Secretary improperly included Exhausted Benefit and Medicare Secondary Payer Days in the SSI%; the Secretary improperly included Part C Days in the SSI%; and, the Secretary used an improper matching methodology in the SSI%.
[19] Board Rule 4.5 at 3, Mar. 1, 2013.

right from a realignment request. Therefore, the Board finds it lacks jurisdiction over the entire DSH/SSI% (Provider Specific) issue and dismisses it from the case.

ME Days

In *Barberton Citizens Hosp. v. CGS Administrators*, PRRB Dec. No. 2015-D5 (March 19, 2015) ("*Barberton*"), the Board states, "pursuant to the concept of futility in *Bethesda*, the Board has jurisdiction of a hospital's appeal of additional [ME] days for the DSH adjustment calculation if that hospital can establish a practical impediment" as to why it could not claim these days when it filed its cost report.[20] Lee Regional submitted a Jurisdictional Response and an Alert 10 Response which explained that, through no fault of its own, Lee Regional was prevented from claiming additional ME Days at the time it filed its cost report. This was due to a common circumstance in which the state of Virginia was unable to verify additional ME Days. The Provider explains it is required to first submit an eligibility inquiry to the state agency for each patient treated during the cost reporting period. The Provider states that there are delays between when an eligibility determination is made and when that determination is made available to the Provider. Based on the rationale in *Barberton*, the Board finds that the Provider established a practical impediment for filing ME Days on its cost report.

The Board concludes that it lacks jurisdiction over the DSH/SSI% (Provider Specific) issue, but has jurisdiction over the ME Days issue in this appeal. Case No. 13-2601 will remain open for ME Days and be scheduled for a hearing under separate cover. Review of this jurisdictional decision is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1835(a) and 405.1877 upon final disposition of 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

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

[20] *Barberton* at 4.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

APR 2 7 2018

Case No. 13-1844

Certified Mail

James F. Flynn, Esq.
Bricker & Eckler LLP
100 South Third Street
Columbus, OH 43215-4291

Re: Doctors Hospital – Columbus (36-0152)
FYE 06/30/2008

Dear Mr. Flynn:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in Case No. 13-1844. The Board hereby determines that it lacks jurisdiction in this case. Case No. 13-1844 is now closed.

Background

Doctor's Hospital ("Doctor's" or "Provider") filed an Appeal Request with the Board. The Provider identified the issue under appeal as follows:

> (1) Effect of Prior Year Adjustment(s)
> Issue Statement: "The resolution of issues raised by the provider on appeal regarding adjustments made in previous years is reasonably believed to affect the amount of program reimbursement that the provider should receive in this appealed year."
>
> Issue Description: "The provider believes that the resolution of all issues currently pending on appeal from prior years is necessary in order to determine whether the adjustments, in the current year, made by the [Medicare Contractor] are correct. The resolution of certain issues is reasonably believed to have a 'flow-through' effect that influences adjustments made by the [Medicare Contractor] in subsequent years such as this one."
>
> Amount in Controversy: Provider reasonably believes amount to be in excess of $10,000, but unable to calculate it at this time since it is dependent upon resolution of other pending appeals from earlier-issued NPRs.[1]

[1] Individual Appeal Request Tab 3, Apr. 22, 2013. Doctor's appealed its Notice of Program Reimbursement issued on Oct. 24, 2012.

The Medicare Administrative Contractor, CGS Administrators ("CGS" or "Medicare Contractor"), filed a Jurisdictional Challenge to the appeal.[2] CGS asserts that the appeal request violated Board Rules because it lacks specificity; it did not reference adjustments; and, it lacked a calculation of the amount in controversy. CGS argues that the Provider failed to satisfy Board Rule 7.1, which requires the Provider to identify the disputed adjustment, including the adjustment number and how it should be decided differently. CGS argues that the Provider did not include an adjustment report and no adjustments were identified in its appeal request.[3]

CGS further argues that the Provider violated Board Rule 8, which states that if an issue has multiple components, the provider must specifically identify the items in dispute, and each contested component must be appealed as a separate issue and described as narrowly as possible. CGS states that the general terms of the Appeal Request do not allow a defensible response. The Provider fails to identify any "prior year" issues that are discussed. Instead, CGS argues, "the language is absolutely vague in that the reader cannot even at a minimum determine if this issue relates to DSH, IME/GME, or other factors."[4] Moreover, the Provider failed to include a calculation of the reimbursement effect as required by Board Rule 6.3.[5] CGS requests that the Board "dismiss this case since the sole issue is so vaguely stated and defined in violation of the PRRB rules, that it cannot be determined with certainty what part of the determination the Provider disputes or if the actual disputed issue(s) meet the Board Jurisdictional requirement of $10,000 in reimbursement impact."[6]

The Provider filed a Jurisdictional Response, arguing that the issue appealed was "Effect of Prior Year Adjustment(s)."[7] It wrote that it "appealed the potential understatement of the Provider's FY 2008 reimbursement as a result of [the 'flow-through' effect of] adjustments and reopenings."[8] The Provider states that some Medicare Contractors have taken the position that, in order to recognize any such effects in subsequent years, the provider must have an appeal pending that raises the particular issue.[9] Doctor's states:

> In this appeal, the Provider is preserving its right to appeal any such issue in order that it may receive the reimbursement to which it is entitled. The only other means available to the Provider to protect its FY 2008 reimbursement in the event of a prior year reopening with a "flow through" effect is to request a reopening of FY 2008; however, pursuant to 42 C.F.R. § 405.1885, a [Medicare Contractor's] decision whether or not to reopen is discretionary and not subject to Provider appeal. As a result, there is no other means available to the Provider to protect its right to flow through effect reimbursement in FY 2008.[10]

Doctor's reiterated that its issue is the "resolution of issues raised by the provider on appeal regarding adjustments made in previous years, as such adjustments will affect the Provider's

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[2] CGS' Jurisdictional Challenge, Apr. 30, 2014.
[3] Jurisdictional Challenge at 1.
[4] *Id.* at 2.
[5] *Id.*
[6] *Id.*
[7] Doctor's Jurisdictional Response at 1, May 30, 2014.
[8] Jurisdictional Response at 2.
[9] *Id.* at 3.
[10] *Id.* at 3-4.

reimbursement in FY 2008."[11] Doctor's states that this description provides sufficient identification of the issue in compliance with Board Rule 7.1.[12]

Board Determination

A provider is entitled to a hearing before the Board if (1) such provider is dissatisfied with a final determination of the Medicare Contractor as to its amount of total program reimbursement due the provider; (2) the amount in controversy is $10,000 or more; and, (3) such provider files a request for a hearing within 180 days after notice of the final determination.[13] The related regulations and Board rules describe in more detail what is required in order to file a hearing request with the Board. 42 C.F.R. § 1841 states in pertinent part:

> Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position.

The Board Rules state, "[f]or each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction."[14] Board Rule 7.1A requires a concise issue statement describing the adjustment, including the adjustment number; why the adjustment is incorrect; and, how the payment should be determined differently.[15] Alternatively, if the Provider does not have access to the underlying information, it is to describe why that information is not available.[16]

Doctor's appealed the "flow-through effect" from any prior appeals. The Provider did not cite to any audit adjustments or specify which determination(s)/issue(s) from other appeals it was referring to. The Board is unable to determine what issue is in dispute. Therefore, the Board finds that Doctor's appeal lacks specificity as required by Board Rule 7.1A. As this was the only issue in the case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

cc: Judith E. Cummings, CGS Administrators
Wilson C. Leong, Esq., CPA, Federal Specialized Services

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[11] *Id.* at 4.
[12] *Id.*
[13] 42 U.S.C. § 1395oo(a).
[14] Board Rule 7 at 6 (Mar. 1, 2013).
[15] Board Rule 7.1A at 6.
[16] Board Rule 7.1B at 6.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
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CERTIFIED MAIL

APR 2 7 2018

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

RE: Quorum Health 2005 Post 1498R SSI Data Match Group, CN 16-2322GC

Specifically the following participants with pending individual appeals:

- Gateway Regional Medical Center, 14-0125, 12/31/2005, CN 17-0468
- Scenic Mountain Medical Center, 45-0653, 12/31/2005, CN 17-0414

Dear Mr. Hales:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned group and the related individual appeals. We note that each of the Providers listed above appealed from a revised Notice of Program Reimbursement (RNPR) for a 2005 cost reporting period. The RNPRs, which were issued after May 2016, were issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). Both Providers are also appealing the Medicaid Eligible Days issue in their individual appeals. The specific facts with regard to each Provider and the Board's determinations are set forth below:

SSI Provider Specific Issue

One of the two issues in each individual appeal in case numbers **17-0468 and 17-0414** is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. Each of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue directly into the CIRP group, case number 16-2322GC.

The Providers are appealing two components of the SSI Percentage: 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.

With regard to 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—the Board finds it is duplicative of the Systemic Errors issue that was directly added to 16-2322GC and this aspect is hereby dismissed from the individual appeals.[1]

[1] Providers' Individual Appeal Requests at Tab 3, Issue 1 and Appeal Request in 16-2322GC.

With regard to the second aspect of the SSI Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—the Board finds it lacks jurisdiction and dismisses this aspect of the issue. 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.

Medicaid Eligible Days Issue

The Providers in case numbers **17-0468 and 17-0414** also appealed the Medicaid Eligible Days issue from RNPRs. The Providers contend that the Medicare Contractor ". . . failed to include all Medicaid eligible days, including . . . Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation."[2] Both Providers also referenced audit adjustments 5 and 6 for the Medicaid Eligible Days issue.

For both Providers, audit adjustments 5 and 6 on the RNPRs relate to adjustments to the DSH payment percentage on Worksheet E, Part A based on the hospitals' SSI percentages for cost reporting periods after 10/1/2004 and before 10/1/2005. Since the Medicaid Eligible Days issue was not adjusted in the RNPRs, the Board does not have jurisdiction over these Providers' appeals pursuant to 42 C.F.R. § 405.1889. This regulation states that any matter not specifically revised may not be considered in any appeal of the revised determination.

Therefore, the Board finds it lacks jurisdiction and dismisses the Medicaid Eligible Days issue from case numbers 17-0468 and 17-0414. Since there are no other issues in these appeals, the cases are hereby closed and removed from the Board's docket.

Review of the jurisdictional 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:
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Robert A. Evarts, Esq.

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: Byron Lamprecht, Wisconsin Physicians Service (J-8)
Maureen O'Brien Griffin, Hall, Render, Killian, Heath & Lyman
Wilson C. Leong, Esq., CPA, Federal Specialized Services

[2] *See* Providers' individual appeal requests at Tab 3, Issue 2.