DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUN 01 2018

Certified Mail

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

RE: **EJR Determination Hall Render DSH Dual Eligible SSI Patient Days Groups**

13-1678GC	Good Shepherd Health System 2006 DSH SSI Fraction Baystate Errors Group
13-2160GC	LifePoint 2010 DSH Medicare Fraction Dual Eligible Days Group
13-2274GC	Capella Healthcare 2010 Medicare Fraction Dual Eligible Days Group
13-3067GC	Ascension Health 2010 DSH Medicare Fraction Dual Eligible Days
13-3670GC	Baptist Health Arkansas 2010 DSH SSI Fraction Dual Eligible Group
14-0650G	Hall Render 2010 DSH Medicare Fraction Dual Eligible Days Group
14-1022G	Hall Render 2011 DSH SSI Fraction Dual Eligible Days Group
14-3286G	Hall Render 2012 DSH SSI Ratio Dual Eligible Days Group
15-1024G	Hall Render 2008 DSH Medicare Fraction Dual Eligible Days Group II
15-1672G	Hall Render 2011 DSH SSI Fraction Dual Eligible Days Group II
15-1869G	Hall Render 2010 DSH SSI Fraction Dual Eligible Days Group II
15-1876G	Hall Render 2013 DSH SSI Fraction Dual Eligible Days Group
15-2256G	Hall Render 2009 SSI Fraction Dual Eligible Days Group II
15-2644G	Hall Render 2012 DSH SSI Fraction Dual Eligible Days Group II
16-1522G	Hall Render 2011 DSH Medicare Fraction Dual Eligible Group III
16-1610G	Hall Render 2013 DSH SSI Fraction Dual Eligible Days Group II
16-1707G	Hall Render 2012 DSH SSI Fraction Dual Eligible Days Optional Group III
16-2148G	Hall Render 2014 DSH SSI Fraction Dual Eligible Days Group
16-2390GC	Community Healthcare System 2014 DSH SSI Fraction Dual Eligible Days Group
17-0061G	Hall Render 2005 DSH Medicare Fraction Dual Eligible Days Group
17-0489G	Hall Render 2006 DSH SSI Ratio Dual Eligible Days Group II

Dear Ms. Griffin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 3, 2018 request for expedited judicial review (EJR) (received May 4, 2018) in the above-referenced appeals. The Board's decision with respect to jurisdiction and EJR is set forth below.

Issue in Dispute

The issue for which the Board is considering EJR is:

> Whether the Provider's Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' (MACs') failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[1]

Medicare Disproportionate Share Hospital (DSH) Payment Background

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] One of the PPS payment adjustments is the DSH payment adjustment. The Secretary is required to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients."[4] Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends on the hospital's "disproportionate patient percentage" (DPP).[5]

The DPP is defined as the sum of two fractions expressed as a percentage.[6] Both of these fractions look, in part, to whether or not the hospital's patients for such days claimed during the particular cost reporting period were "entitled to benefits" under Medicare Part A. The first fraction used to compute the DSH payment is commonly known as the Medicare fraction. It is also referred to as the SSI fraction because the numerator is determined by the number of patient days for which the patient was entitled to SSI. The statute defines the SSI fraction as:

> (I) 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

[1] Providers' EJR Request at 2.
[2] 42 U.S.C. §§ 1395ww(d)(1)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[5] 42 U.S.C. § 1395ww(d)(5)(F)(v)
[6] 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> (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 . . .[7]

The SSI fraction is computed annually by CMS, and the MACs are required to use CMS's calculation to compute a hospital's DSH payment adjustment.[8]

The second fraction used to compute the DSH payment is the Medicaid fraction, defined as:

> (II) 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 of this chapter, 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.[9] .

According to CMS' regulation, "[t]he [MAC] 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]

Baystate Medical Center, an inpatient PPS provider, challenged the data matching process used to determine the SSI fraction of the DSH computation resulting in the decision in *Baystate Medical Center v. Leavitt.*[11] In that case, the District Court concluded that, in certain respects, the Secretary's matching process did not use "the best available data" to match Medicare patient day information with SSI eligibility data when calculating the SSI fractions. As a result, the Secretary revised the data match process used in the calculation the SSI fractions for Federal fiscal year (FFY) 2011 and forward[12] and the CMS Administrator issued CMS Rulings 1498-R and 1498-R2 to make retroactive corrections to the SSI fractions for FFYs prior to 2011.[13] In the August 16, 2010 final inpatient PPS rule, the Secretary announced that the only Payment Status Codes (PSCs) that would be used to describe an individual as eligible for SSI benefits during a given month were C01, M01 and M02.[14]

---

[7] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (emphasis added).
[8] 42 C.F.R. § 412.106(b)(2)-(3).
[9] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added).
[10] 42 C.F.R. § 412.106(b)(4).
[11] 545 F. Supp. 2d 20, as amended 587 F. Supp. 2d 37 (D.D.C. 2008).
[12] 75 Fed. Reg. 50042, 50275-277 (Aug. 16, 2010).
[13] *See* CMS Rulings on the internet at https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html (last visited May 21, 2018).
[14] 75 Fed. Reg. at 50,218.

Providers' Request for EJR

The Providers assert that under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration (SSA) for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[15]

The Providers note that in administering the SSI program, SSA assigns each beneficiary a PSC. The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[16] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the Medicare statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' DPP calculations which they are entitled to under Section 951 of the Medicare Prescription Drug, Improvement and Modernization Act, P.L. 108-173.

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.

[15] *Id.* at 50,275-286.
[16] *Id.* at 50,281.

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2005, 2006, and 2008-2014. Each of the Providers received an NPR or RNPR with a SSI% calculated after the issuance of the August 16, 2010 2011 IPPS Final Rule, which updated CMS' SSI data matching methodology.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[17] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[18]

On August 21, 2008, new regulations governing the Board were effective.[19] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[20] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[21]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left

[17] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[18] *Bethesda at 1258-59.*
[19] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[20] 201 F. Supp. 3d 131 (D.D.C. 2016)
[21] *Banner* at 142.

it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest. The Board finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. Consequently, the Board finds that it has jurisdiction over the Providers in these cases with the exceptions noted below.

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

Case No. 15-1672G: #2 North Arkansas Regional Medical Center (provider no. 04-0017, FYE 3/31/2011)
Case No. 13-3067G: #11 St. Mary's of Michigan (provider no. 23-0077, FYE 6/30/2010)

Since the SSI issue that is the subject of these appeals was not adjusted in the revised NPR, the Board does not have jurisdiction over the 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. The Board hereby dismisses North Arkansas Regional Medical Center and St. Mary's of Michigan from their respective appeals appeal and since jurisdiction is a prerequisite to granting EJR, the Providers' requests for EJR are denied.

Additionally, the Board finds that as part of the issue description in the EJR request, that the Providers were also seeking a ruling "that the CMS has failed to provide the Providers with adequate information to allow them to check and challenge CMS's disproportionate patient percentage (DPP) calculations". The Providers stated that they are entitled to the data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173 and the summary that CMS provides does not allow providers to meaningfully challenge their DPP calculations. This 951 challenge was not included in the original appeal requests, and is unrelated to the issue being challenged as part of this group appeal. The addition of this new issue to a group appeal violates two regulatory provision, 42 C.F.R. § 1835(c) and 42 C.F.R. § 1837(a)(2). 42 C.F.R. § 1835(c) provides that Providers can only add issues within 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) of this section and 42 C.F.R. § 1837(a)(2) limits group appeals to one issue. Therefore, the Board dismisses the Providers' request for a ruling on the release of data pursuant to Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173 as it is not part of this group appeal.

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

Legal Authority

42 C.F.R. § 405.1867 defines the sources of the Board's authority, stating:

> In exercising its authority to conduct the hearings described herein, the Board must comply with all the provisions of title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator of the Centers for Medicare & Medicaid Services . . . . The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

The group challenges CMS' statutory interpretation of the term "entitled" as used in the Social Security Act § 1858(d)(5)(F)(vi)(I) and the application of that term in the DSH SSI fraction's[23] matching process, as published in the August 16, 2010 2011 IPPS Final Rule. The Board finds that this is a challenge to the substantive validity of the DSH methodology described in the DSH regulation. The Board determines that, consequently, it lacks the authority to decide the legal question relevant to the matter at issue (that "entitled," as used in the DSH regulation, should be applied the same way for Part A and SSI days in terms of "covered/paid" days in the SSI fraction).

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 remaining participants in these group appeals are entitled to a hearing before the Board (but for the Providers dismissed above);

2) based upon the participants' assertions regarding 42 U.S.C. § 1395ww(d)(5)(F)(vi) and 75 Fed. Reg. 50042, 50275-277 (Aug. 16, 2010) 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 75 Fed. Reg. 50042, 50275-277 (Aug. 16, 2010), is valid.

Accordingly, the Board finds that the question of the validity of 75 Fed. Reg. 50042, 50275-277 (Aug. 16, 2010) 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

---

[23] Also known as the Medicare fraction in the DSH payment.

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:

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: Mounir Kamal, Novitas Solutions (Certified Mail w/Schedules of Providers)
Cecile Huggins, Palmetto GBA (Certified Mail w/Schedules of Providers)
Bryon Lamprecht, WPS (Certified Mail w/Schedules of Providers)
Danene Hartley, NGS (Certified Mail w/Schedules of Providers)
Laurie Polson, Palmetto GBA (Certified Mail w/Schedules of Providers)
Wilson Leong, FSS (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

JUN 0 4 2018

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

RE: St. Joseph Hospital, Provider No. 15-0047, FYE 5/31/2009, Case No. 17-2221 & as a participant in QRS CHS 2009 DSH SSI Percentage CIRP Group, Case No. 18-1316GC

Dear Mr. Ravindran:

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

Pertinent Facts:

Community Health Systems (CHS) filed an individual appeal for St. Joseph Hospital's 2009 FYE on September 14, 2017. The appeal is based on the revised Notice of Program Reimbursement (RNPR) dated March 13, 2017. There are three issues under appeal:

- SSI Provider Specific
- SSI Systemic
- DSH Medicaid Eligible Days

For all three issues, CHS identified audit adjustments 5 and 6. Audit Adjustment 5 was adjusted to remove non-allowable Medicaid days on Worksheet S-3, Part I and Audit Adjustment 6 was to adjust the hospital DSH payment percentage to disallow non-allowable Medicaid days on Worksheet E, Part A.

In a letter dated April 9, 2018, the Medicare Contractor objected to the Board's jurisdiction over the SSI Provider Specific issue for two reasons:

1) It has not made a determination with regard to the SSI Provider Specific issue as the Provider has not yet made a formal request for a realigned SSI percentage based on its own fiscal year end.
2) The other component of the SSI Provider Specific issue regarding whether the Medicare Contractor used the correct SSI% in computing the DSH calculation is duplicative of the Systemic issue under appeal.

CHS filed a responsive jurisdictional brief on May 10, 2018. CHS contends that the Board has jurisdiction over the Provider Specific issue as it is a separate component which is distinct from the Systemic issue. The Provider is ". . . addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[1] Further the Representative advises that it is not seeking SSI realignment.

---

[1] Representative's jurisdictional brief dated May 9, 2018 at 2.

On May 23, 2018, CHS authorized Quality Reimbursement Services, Inc. (QRS) to form a new common issue related party (CIRP) group. The group was formed with St. Joseph Hospital, by transferring the SSI Systemic issue from its individual appeal, case number 17-2221. The Board established the CIRP group, to which it assigned case number 18-1316GC.

Board Determination:

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

In this case, the Provider's appeal was filed from a RNPR.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

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

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

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

In this case, the Board finds that it does not have jurisdiction over the SSI Provider Specific and SSI Systemic issues. As noted, CHS cited audit adjustments 5 & 6 for both SSI issues. According to the adjustment report submitted with the appeal request, Adjustment 5 was adjusted

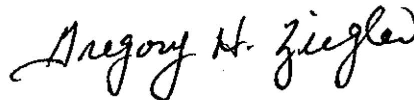
to remove non-allowable Medicaid days on Worksheet S-3, Part I and Adjustment 6 was to adjust the hospital DSH payment percentage to disallow non-allowable Medicaid days on Worksheet E, Part A. There is no evidence to support an adjustment to the SSI Percentage on the RNPR under appeal.

Therefore, the SSI Provider Specific and SSI Systemic issues are hereby dismissed from case number 17-2221. The individual appeal will, however, remain pending for the Medicaid Eligible Days issue. Further, because St. Joseph Hospital was the sole participant used to form the new SSI Percentage CIRP group (case number 18-1316GC), and the Board has found that it does not have jurisdiction over the SSI Percentage issue for this Provider, the Board is also dismissing the group appeal.

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

Board Members Participating:
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) and 42 C.F.R. §§ 405.1875 and .1877

cc: Byron Lamprecht, Wisconsin Physicians Service
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUN 04 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**

14-2815GC	Memorial Health System of East Texas 2009 DSH SSI MA Days Medicaid Fraction CIRP
15-3205	Saint Mary's Medical Center, Provider No. 51-0007, FYE 9/30/2012
15-3207	Saint Mary's Medical Center, Provider No. 51-0007, FYE 9/30/2011
16-2538	Saint Mary's Medical Center, Provider No. 51-0007, FYE 9/30/2013

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 16, 2018 requests for expedited judicial review (EJR) (received May 17, 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,

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

Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

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

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

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

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

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the

---

[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)(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).

> 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]

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

---

[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 beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C*

[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 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 these cases 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

---

[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.

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 2009, 2011, 2012 and 2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[23] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[24]

On August 21, 2008, new regulations governing the Board were effective.[25] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[26] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could

[23] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[24] *Bethesda at 1258-59.*
[25] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[26] 201 F. Supp. 3d 131 (D.D.C. 2016)

not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[27]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

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 self-disallowed the issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy for the individual appeals exceeds $10,000 and in the group appeal, exceeds the $50,000 threshold[28] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request cover fiscal years 2009, 2011, 2012 and 2013, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

[27] *Banner* at 142.
[28] *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 Providers are entitled to a hearing before the Board;

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

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

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

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

Board Members Participating:

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)
Schedule of Providers for Case No. 14-2815GC

cc: Mounir Kamal, Novitas Solutions (Certified Mail w/Schedule of Providers)
Laurie Polson, Palmetto GBA c/o National Government Services (J-M) (w/o Schedule)
Wilson Leong, Esq., 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

JUN 1 3 2018

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

RE: EJR Determination for:

18-0483GC	HRS Lafayette General Health FFY 2018 ATRA IPPS 0.7% Rate Reduction Group
18-0484G	HRS FFY 2018 ATRA IPPS 0.7% Rate Reduction Group
18-0493GC	HRS WKHS FFY 2018 ATRA IPPS 0.7% Rate Reduction Group
18-0495GC	HRS Cottage Health FFY 2018 ATRA IPPS 0.7% Rate Reduction Group
18-0497GC	HRS Prime Healthcare FFY 2018 ATRA IPPS 0.7% Rate Reduction Group
18-0511GC	HRS FMOLHS FFY 2018 ATRA IPPS 0.7% Rate Reduction Group
18-0527GC	HRS ProMedica Health System FFY 2018 ATRA IPPS 0.7% Rate Reduction Group
18-0597GC	HRS UHHS FFY 2018 ATRA IPPS 0.7% Rate Reduction Group
18-0616GC	HRS CCF FFY 2018 ATRA IPPS 0.7% Rate Reduction Group
18-0617GC	HRS Health Quest FFY 2018 ATRA IPPS 0.7% Rate Reduction Group
18-0830GC	HRS SCHS FFY 2018 ATRA IPPS 0.7% Rate Reduction Group
18-0833GC	HRS Alecto Healthcare FFY 2018 ATRA IPPS 0.7% Rate Reduction Group
18-0834GC	HRS LLUH FFY 2018 ATRA IPPS 0.7% Rate Reduction Group
18-0836EC	HRS MSHS FFY 2018 ATRA IPPS 0.7% Rate Reduction Group

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 30, 2018 requests for expedited judicial review (EJR) (received June 1, 2018) for the above-referenced appeals. The decision of the Board is set forth below.

Issue in Dispute

The Providers are challenging:

> Whether CMS acted unlawfully by failing to make a positive adjustment of 0.7% to the Inpatient Prospective Payment System ("IPPS") rates in [F]ederal fiscal year ("FFY") 2018 to reverse the effect of a negative adjustment of 0.7% made over fiscal years 2014 through 2017, which has reduced the Providers' Medicare

> reimbursement in FFY 2018 and will continue to do so in perpetuity.[1]

Statutory and Regulatory Background

In the Federal year (FY) 2008 inpatient prospective payment system (IPPS) final rule[2], the Secretary[3] adopted the Medicare severity diagnosis-related group (MS–DRG) patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. This Secretary believes that by increasing the number of MS–DRGs and more fully taking into account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs encourage hospitals to improve their documentation and coding of patient diagnoses.[4]

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

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

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

---

[1] Providers' EJR requests at 1.
[2] 72 FR 47,130, 47140 through 47189 (Aug. 22, 2007)
[3] of the Department of Health and Human Services.
[4] 81 Fed. Reg. 56,762, 56,780 (Aug. 22, 2016).
[5] 82 Fed. Reg. 37,990, 38,008 (Aug. 17, 2017).
[6] *Id.*
[7] 82 Fed. Reg. at 38,008.

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

The adjustment required under section 631 of the ATRA was a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, the Secretary anticipated that any adjustment made to reduce payment rates in one year would eventually be offset by a positive adjustment in 2018, once the necessary amount of overpayment was recovered. However, section 414 of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, Public Law 114–10, replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. However, section 15005 of the 21st Century Cures Act (Pub. L. 114–255), reduced the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points. [8]

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

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

In the FY 2017 IPPS/LTCH PPS proposed rule,[12] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY

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

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

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

The FY 2018 Federal Register (August 14, 2017)

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

> Several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FY 2017 under section 631 of the ATRA, which exceeded the estimated adjustment of approximately -0.8 percentage point described in the FY 2014 IPPS/LTCH PPS rulemaking. **Commenters contended that, as a result, hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA. They asserted that CMS' proposal to apply a 0.4588 percent positive adjustment for FY 2018 misinterprets the relevant statutory authority, and urged CMS to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FY 2018; that is, the difference between the -1.5 percentage point adjustment made in FY 2017 and the initial estimate of -0.8 percentage point discussed in the FY 2014 IPPS/LTCH PPS rulemaking.** Commenters also urged CMS to use its discretion under section 1886(d)(5)(I) of the Act to increase the FY 2018 adjustment by 0.7 percentage point. Other commenters requested

[13] *Id.*
[14] 82 Fed. Reg. at 38,008-9.
[15] *Id.* at 38009.

> that, despite current law, CMS ensure that adjustments totaling the full 3.9 percentage points withheld under section 631 of the ATRA be returned.
>
> *Response:* As discussed in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56783 through 6785), CMS completed the $11 billion recoupment required under section 631 of the ATRA. We continue to disagree that section 414 of the MACRA was intended to augment or limit our separate obligation under the ATRA to fully offset $11 billion by FY 2017, as we discussed in response to comments in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56784). Moreover, as we discussed in the FY 2018 IPPS/LTCH PPS proposed rule, we believe the directive regarding the applicable adjustment for FY 2018 is clear. While we had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA, section 414 of the MACRA requires that we not make the single positive adjustment we intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. As noted by the commenters, and discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, section 414 of the MACRA would not fully restore even the 3.2 percentage point adjustment originally estimated by CMS in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50515). Finally, Public Law 114–255, which further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point, was enacted on December 13, 2016, after CMS proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under section 631 of the ATRA in the FY 2017 rulemaking.
>
> After consideration of the public comments we received, we are finalizing the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under section 15005 of Public Law 114–255. (emphasis added)[16]

Providers' Request for EJR

The Providers contend that the Secretary was required by statute to make a 0.7 percent positive adjustment to the standardized amount in FFY 2018 and the refusal to do so was unlawful. The Providers point out that the Secretary's authority to make ATRA adjustments comes from Section 7(b)(1)(B)(ii) of the TMA, as amended. Section 7(b)(2) of the TMA specifies that any adjustment made under Section 7(b)(1)(B) "for discharges occurring in a year shall not be included in the determination of standardized amounts for discharges occurring in a subsequent year." The Providers contend that the Secretary has violated this directive by failing to make a 0.7 percent curative adjustment in 2018. As a result, the Providers believe, the Secretary will recoup more than $11 billion authorized by ATRA, which constitutes agency action "in excess of

[16] 82 Fed. Reg. at 38009.

statutory jurisdiction, authority, or limitations, or short of statutory right."[17] The Providers note that, at a minimum, the Secretary has the discretion to restore this cut under his power to implement "exceptions and adjustments" to the standardized amount "as [CMS] deems appropriate."[18] The Providers argue that the Secretary, therefore, has committed a reversible error in stating in the IPPS Final Rule for 2018 that he did not have the authority to make this curative adjustment.[19] Not only is the Secretary error regarding his own authority reason enough to remand the issue to the Secretary for further consideration, the Secretary's failure to act on his authority to restore the act is "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law."[20]

Decision of the Board

The Board concludes that it lacks the authority to grant the relief sought by the majority of Providers, to apply a positive adjustment of 0.7 percent to the IPPS standard amount. Consequently, the Board hereby grants the Providers' request for EJR for the issue and FFY under dispute with the exception of the Providers below. Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1), the Board is required to grant an EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling. In these cases, Providers filed timely appeals of the August 14, 2017 Federal Register notice[21] and the amount in controversy exceeds the $50,000 threshold for jurisdiction over each group.[22] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Case Number 18-0497GC: # 29 Saint Michael's Medical Center

The Provider, above, did not included in letter of representation submitted with its original hearing request or the Schedule of Providers and associated jurisdictional documents filed with the EJR request. Board Rule 5[23] requires that a provider submit a letter designating its representative on its letterhead. In case number 18-0497GC, the Provider Representative filed a letter of representation with an attached list of Providers with the original hearing request and placed an identical letter under Tab H of the jurisdictional documents. Both of these letters omitted St. Michael's Medical Center. Since the Saint Michael's Medical Center did not comply with Board Rule, by authorizing Healthcare Reimbursement Services as its representative, the Board hereby dismisses the Provider from case number 18-0497GC. Since the Provider is no

[17] 5 U.S.C. § 706(2)(C).
[18] 42 U.S.C. § 1395ww(D)(5)(I).
[19] 82 Fed. Reg. at 38,009.
[20] 5 U.S.C. § 706(2)(A).
[21] In accordance with the Administrator's decision in *District of Columbia Hospital Association Wage Index Group Appeal,* (HCFA Adm. Dec. January 15, 1993) *Medicare & Medicaid Guide* (CCH) ¶ 41,025, a notice published in the Federal Register is a final determination.
[22] *See* 42 C.F.R. § 405.1837.
[23] The Board's Rules are found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.html.

longer a participant in the appeal, Saint Michael's Medical Center's request for EJR is hereby denied.

The Board finds that:

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

2) based upon the participants' assertions regarding the 0.7 percent reduction to the IPPS standardized amount, there are no findings of fact for resolution by the Board;

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

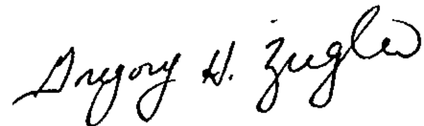
4) it is without the authority to decide the legal question of whether the 0.7 percent reduction to the IPPS standardized amount, is valid.

Accordingly, the Board finds that the question of the validity of the 0.7 percent reduction to the IPPS rate properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the providers' request for EJR for the issue and the subject year. The providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Board Members Participating:

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: Pam VanArsdale, NGS (Certified Mail w/ Schedules of Providers)
Loraine Frewert, Noridian Healthcare Solutions (Certified Mail w/ Schedules of Providers)
Bryon Lamprecht, WPS (Certified Mail w/ Schedules of Providers)
Mounir Kamil, Novitas Solutions (Certified Mail w/ Schedules of Providers)
Laurie Polson, Palmetto GBA c/o NGS (Certified Mail w/ Schedules of Providers)
Judith Cummings, CGS (Certified Mail w/ Schedules of Providers)
Wilson Leong, FSS (w/Schedules of Providers) (Certified Mail w/ Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUN 1 4 2018

CERTIFIED MAIL

West Virginia University Medicine
Nancy Repine
Assistant Vice President,
Finance & Reimbursement
3040 University Avenue
Morgantown, WV 26506

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

RE: City Hospital
Provider No. 51-0008
FYE 12/31/2013
PRRB Case No. 16-1331

Dear Ms. Repine and Ms. Polson,

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

City Hospital is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in an Original Notice of Program Reimbursement (NPR) dated October 1, 2015. The Provider filed a timely appeal from the NPR on March 24, 2016. The Model Form A-Individual Appeal Request, Tab 3, presented nine issues. On November 23, 2016, the Provider requested to transfer seven issues to group appeals, including the SSI Systemic Errors issue to case no. 17-0567GC. The Provider later requested to withdraw the Medicaid Eligible Days issue. The remaining issue in the appeal is the SSI Provider Specific issue.

Board's Decision

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

The first aspect of the SSI Provider Specific issue—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was transferred to 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 the SSI Provider Specific issue also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[3] The 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 transferred to a group appeal, the Board hereby dismisses this aspect of the SSI Provider Specific issue.

The second aspect of the issue—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 for City Hospital and dismisses the issue from the appeal. As this was the last issue in the appeal, PRRB Case No. 16-1331 is hereby closed and removed from the Board's docket.

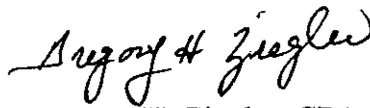
Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

---

[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.

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

FOR THE BOARD



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

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUN 1 5 2018

CERTIFIED MAIL

West Virginia University Hospital
Amy J. Stephens
Director
Corporate Finance & Reimbursement
P.O. Box 8261
Morgantown, WV 26505

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

RE: West Virginia University Hospital
Provider No. 51-0001
FYE 12/31/2013
PRRB Case No. 16-2499

Dear Ms. Stephens and Ms. Polson,

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

West Virginia University Hospital is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in an Original Notice of Program Reimbursement (NPR) dated March 24, 2016. The Provider timely filed an appeal from the NPR on September 19, 2016. The Model Form A- Individual Appeal Request, Tab 3, presented two issues: DSH SSI Provider Specific and DSH SSI Systemic Errors. The Provider requested that the SSI Systemic Errors Issue be transferred to a group appeal, case no. 17-0567GC. The only remaining issue in the appeal is the SSI Provider Specific issue.

Board's Decision

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

The first aspect of the SSI Provider Specific issue—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was transferred to 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 transferred to a group appeal, the Board hereby dismisses this aspect of the SSI Provider Specific issue.

The second aspect of the issue—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

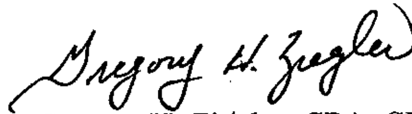
The Board finds that it does not have jurisdiction over the SSI Provider Specific issue in case no. 16-2499 for West Virginia University Hospital. As this was the last issue in the appeal, PRRB Case No. 16-2499 is hereby closed and removed from the Board's docket.

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.

---

[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.

FOR THE BOARD



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

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

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUN 15 2018

CERTIFIED MAIL

West Virginia University Hospital
Amy J. Stephens
Director
Corporate Finance & Reimbursement
P.O. Box 8261
3040 University Avenue
Morgantown, WV 26505

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

RE: United Hospital Center
Provider No. 51-0006
FYE 12/31/2013
PRRB Case No. 16-2474

Dear Ms. Stephens and Ms. Polson,

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

United Hospital Center is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in an Original Notice of Program Reimbursement (NPR) dated March 15, 2016. The Provider filed a timely appeal from the NPR on September 12, 2016. The Model Form A- Individual Appeal Request, Tab 3, presented two issues: SSI Provider Specific and SSI Systemic Errors issues. The Provider requested that the SSI Systemic Errors Issue be transferred to a group appeal, case no. 17-0567GC. The only remaining issue in the appeal is the SSI Provider Specific issue.

Board's Decision

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

The first aspect of the SSI Provider Specific issue—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was transferred to 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 the issue also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[3] The 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 transferred to a group appeal, the Board hereby dismisses this aspect of the SSI Provider Specific issue.

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—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 and dismisses the issue from this appeal. Because it was the last issue in the appeal, PRRB Case No. 16-2474 is hereby closed and removed from the Board's docket.

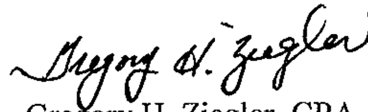
Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

---

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

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

FOR THE BOARD



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

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUN 1 5 2018

CERTIFIED MAIL

Toyon Associates, Inc.
Lisa Ellis
Director – Client Services
1800 Sutter St., Suite 600
Concord, CA 94520-2546

Federal Specialized Services
Edward Lau, Esq.
1701 S. Racine Avenue
Chicago, IL 60608-4058

Dignity Health
Karen Dizon-Villegas
251 South Lake Avenue
Suite 700
Pasadena, CA 91101-4842

Re: Remand from United States District Court for the District of Columbia in:

> CHW FY 2009 Rural Floor Budget Neutrality Group, PRRB Case No. 11-0610GC; and
> Dignity Health 2010 Rural Floor Budget Neutrality Group, PRRB Case No. 12-0340GC
>
> For: Bakersfield Memorial Hospital, Mercy Hospital, and St. Bernadine Medical Center

Dear Ms. Ellis, Ms. Dizon-Villegas, and Mr. Lau,

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the record in light of the remand issued by the United States District Court for the District of Columbia in PRRB Case Nos. 11-0610GC and 12-0340GC. In the Joint Motion to Remand, the Secretary found that the Board erred in dismissing Bakersfield Memorial Hospital from case number 11-0610GC and Bakersfield Memorial Hospital, Mercy Hospital, and St. Bernadine Medical Center in 12-0340GC. In accordance with the ruling, the Board hereby reopens case numbers 11-0610GC and 12-0340GC and finds that it has jurisdiction over these Providers pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840. The Board's decision with respect to Expedited Judicial Review for these Providers is set forth below.

Issue under Appeal

This is a challenge to the Centers for Medicare & Medicaid Services' ("CMS's") application of the statewide rural floor budget neutrality adjustment factor made to the federal fiscal year ("FFY") 2009 [and 2010] wage index used to determine inpatient prospective payment system payments to Medicare Providers. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4410(a), 42 U.S.C. § 1395ww note.

Factual Background and Parties' Arguments

The Medicare statute requires the Secretary of HHS to adjust prospective payment system ("PPS") payments to a hospital to reflect the hospital's labor-related costs relative to the national average labor cost. To account for variances in local labor markets relative to the national average, the Secretary assigns hospitals located within a geographic region an area wage index that adjusts the base payment rate upward or downward to reflect average wage levels in the hospital's local labor market relative to the national average. The Secretary uses census-related proxies to identify local labor markets, which is necessarily inexact. There are numerous exceptions and adjustments in order to account for the inexact use of census areas as proxies, one of which is the rural floor.[1]

The purpose of the rural floor is to raise the urban area wage indexes relative to the national average and thereby raise payments to urban hospitals. Congress required that the rural floor have a budget neutral effect on aggregate Medicare payments nationwide. The Secretary's inpatient PPS final rule for FFY 2009 changed the way the Secretary applied the budget neutrality aspect of the rural floor adjustment. Instead of continuing to adjust the area wage indexes for all hospitals nationwide, the Secretary proposed adjusting wage area indexes on a State-specific level. In response to concerns about the methodology change, the Secretary implemented a transition to the change that would take place over three years using a blended rural floor adjustment.[2]

The Providers argue that the State-specific rural floor budget adjustment is invalid for two reasons. First, the Secretary's decision exceeds her statutory authority because it is at odds with Congressional intent. Secondly, the State-specific method is an arbitrary and capricious approach lacking substantial evidence in the rulemaking record.[3]

BOARD'S DECISION

The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a).

Provider's Contentions

The Providers argue that the issue in these group appeals is suitable for EJR because the Board has jurisdiction over the Providers and issue but does not have the authority to grant the relief sought. The Providers contend that the application of the within-state (or statewide) rural floor budget neutrality adjustment for FFY 2009 and 2010 is contrary to the Medicare statute and that

---

[1] Providers' Final Position Paper at 2-3.
[2] *Id.* at 4-6.
[3] *Id.* at 7.

CMS promulgated that regulation in violation of the Administrative Procedures Act.[4]

The Providers have made three arguments against the within-state rural floor budget neutrality adjustment. First, the Providers argue that the adjustment is invalid because it conflicts with the language of § 4410(b) of the Balanced Budget Act of 1997 and congressional intent. Second, the Providers contend that CMS' adoption of the rule did not comply with the procedural requirements of the Administrative Procedures Act. Third, the Providers claim that the rule is arbitrary and capricious.[5]

According to the Providers, the within-state rural floor adjustment is contrary to statute because it applies the rural floor adjustment to hospitals that it should not have. Section 4410(b) of the Balanced Budget Act states that CMS is to apply the rural floor budget neutrality adjustment to hospitals not described in § 4410(a), which are: urban hospitals with a wage index below the rural floor and rural hospitals in the state where those urban hospitals are located. The Providers argue that they fall into the § 4410(a) and therefore should not have the within-state adjustment applied to them.[6]

The Providers next argue that the within-state RFBNA violated the Administrative Procedures Act (APA) because the proposed rule did not adequately describe "the terms or substance of the proposed rule or a description of the subjects and issues involved" pursuant to 5 USC § 553(b)(3). The proposed rule did not explain how it calculated the within state adjustment and did not explain any alternatives that were considered.[7]

Finally, the Providers contend that the rule is arbitrary and capricious because it leads to wide variations in the wage index in the same area, which the Providers argue is "a result that Congress does not favor."[8]

RFBNA Statutory and Regulatory Background

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services ("CMS"), formerly known as the Health Care Financing Administration ("HCFA"),[9] is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations know as fiscal intermediaries ("FIs") and Medicare Administrative Contractors ("MACs"). FIs and MACs determine payment amounts due the providers under Medicare law, regulation and interpretive guidelines published by CMS.[10]

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). The PPS statute contains a number of provisions that

---

[4]Provider's Response to EJR letter at 2.
[5] *Id.* at 9.
[6] *Id.* at 9-10.
[7] *Id.* at 10-11.
[8] *Id.* at 11.
[9] In 2001, the agency name was changed from HCFA to CMS.
[10] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.

adjust reimbursement based on hospital-specific factors.[11] This case involves the annual changes to the PPS rates for hospital inpatient operating costs (IPPS) and the methodology for determining those rates.

Standardized Amount

42 U.S.C. § 1395ww(d)(2)(A) required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS and they were used in computing the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. § 1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals.[12]

Section 1395ww (d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and non-labor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made.[13]

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (i.e., reclassifying and recalibrating diagnostic related groups ("DRGs")). Outlier payments are also included in the simulations. In FFYs 2007 and prior, CMS stated that: [the] budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the [prior years'] budget neutrality adjustments.[14]

Beginning in FFY 2009, one of the fiscal years currently under appeal, the Secretary applied State level rural floor budget neutrality adjustments to the wage index. This method used a three-year phase-in, transitioning from the national budget neutrality adjustment to a State level budget neutrality adjustment. In FFY 2009, hospitals received a blended wage index that is 20 percent of the State-specific adjustment and 80 percent of a national adjustment to the wage index. In FFY 2010, the blended rate was 50 percent of a State level adjustment and 50 percent of a national adjustment; and for FFY 2011, the adjustment would be made using the State-specific approach entirely.[15] Congress preempted the Secretary's State-specific methodology in the Patient Protection and Affordable Care Act of 2010 (PPACA), Pub. L. No. 111-148. Section

[11] *See* 42 U.S.C. § 1395ww(d)(5).
[12] 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).
[13] 71 Fed. Reg. 47870, 48146 (August 18, 2006).
[14] *Id.* at 48147.
[15] 74 Fed. Reg. 43754, 43825-27 (Aug. 27, 2009); 75 Fed. Reg. 50042, 50160 (Aug. 16, 2010).

3141 of PPACA restored a "uniform, national adjustment to the area wage index" for "all discharges occurring on or after October 1, 2010" (FFY 2011).

The within-state method was incorporated into the regulations at 42 C.F.R. § 412.64(e)(4) (2009) which provides:

> CMS makes an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the Balanced Budget Act of 1997 (Pub.L. 105–33) and the imputed floor under paragraph (h)(4) of this section are equal to the aggregate prospective payments that would have been made in the absence of such provisions. Beginning October 1, 2008, such adjustment will transition from a nationwide to a statewide adjustment, with a statewide adjustment fully in place by October 1, 2010.

The Medicare statute at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), require the Board to grant expedited judicial review 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.

Analysis and Decision

Board Finding Regarding Authority

Pursuant to 42 C.F.R. § 405.1867, the Board must comply with Title XVIII of the Act and its supporting regulations. The Providers contend that the application of the within-state (or statewide) rural floor budget neutrality adjustment for FFY 2009 and 2010 is contrary to the Medicare statute and that CMS promulgated that regulation in violation of the Administrative Procedures Act. The Board finds it lacks the authority to examine this legal question as it pertains to the issue in these group appeals.

Conclusion

Regarding EJR, the Board finds that:

1) based upon the Providers' assertion regarding the invalidity of the within-state rural floor budget neutrality adjustment, there are no findings of fact for resolution by the Board;

2) it is bound by Title XVIII of the Social Security Act and the regulations issued thereunder; and

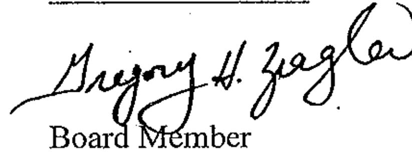
3) it is without the authority to decide the legal question of whether the within-state RFBN adjustment is valid.

Accordingly, the Board finds that the challenge to CMS' application of the statewide rural floor budget neutrality adjustment factor for FFYs 2009 and 2010 properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review 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.

PRRB Case Nos. 11-0610GC and 12-0340GC are hereby closed and removed from the Board's docket.

Board Members Participating
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert Evarts, Esq.

FOR THE BOARD



Board Member

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedules of Providers in case nos. 11-0610GC and 12-0340GC

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

Powers Pyles Sutter & Verville, PC
1501 M Street, NW, 7th Floor
Washington, DC 20005

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUN 15 2018

RE: **18-0361; 13-3174; 14-3132GC; 14-3137GC**

CERTIFIED MAIL

Ms. Kathleen Giberti
Director - Client Services
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

RE: Petaluma Valley Hospital
Provider No.: 05-0136
FYE - 06/30/2008
PRRB Case No.: 18-0361 (and previously 13-3174)

SJHS FY 2008 Accuracy of CMS Developed SSI Ratio Issued 3/16/12 CIRP Group
Provider Nos.: Various
FYE - 06/30/2008
PRRB Case No.: 14-3132GC

SJHS FY 2008 DSH Medicare Dual Elig Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
Provider Nos.: Various
FYE - 06/30/2008
PRRB Case No.: 14-3137GC

Dear Ms. Giberti:

BACKGROUND/PERTINENT FACTS:

CASE NUMBER 18-0361 - Petaluma Valley Hospital, Provider No.: 05-0136, FYE - 06/30/2008:

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, FYE - 06/30/2008. By letter dated December 20, 2017, the Provider Reimbursement Review Board ("Board") acknowledged receipt of the appeal request and assigned case number 18-0361. The appeal is based on a *Revised* Notice of Program dated June 26, 2017. At Tab #3 of the Form A-Individual Appeal Request, the Board notes that the Provider identified two (2) issues in dispute: (1) Medicare Disproportionate Share Hospital ("DSH") Payments - Inclusion of Medicare Part C Days in the SSI Ratio and (2) Medicare Disproportionate Share Hospital ("DSH") Payments - Accuracy of CMS Developed SSI Ratio. The Form A stated that the Provider is commonly owned or controlled by Providence St. Joseph Health.

In the letter accompanying the Form A, Toyon stated that, "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 13-3174 - Petaluma Valley Hospital, Provider No.: 05-0136, FYE - 06/30/2008:

On August 30, 2013, Toyon had filed a Request for Hearing in the matter of Petaluma Valley Hospital, Provider No.: 05-0136, FYE - 06/30/2008. The Board acknowledged receipt of the appeal request and assigned case number 13-3174. The appeal was based on a final determination, the Notice of Program Reimbursement, dated March 8, 2013.

By letter dated August 25, 2015, Toyon advised that it was withdrawing the remaining issue (Issue #5-Medicare Settlement Date (Including Outlier Payments)) and had previously transferred Issue #3-Medicare Disproportionate Share Hospital (DSH) Payments - Accuracy of CMS Developed SSI Ratio Issued March 16, 2012 to CIRP group case number 14-3132GC and Issue #2-Medicare Disproportionate Share Payments - Dual Eligible Part C Days in the SSI Ratio to CIRP group case number 14-3137GC.

Upon the withdrawal of Issue #5 and the transfer of Issues #1-4, Toyon advised that case number 13-3174 could be closed. As a result, the Board closed case number 13-3174 on September 15, 2015.

CASE NUMBER 14-3132GC - SJHS FY 2008 Accuracy of CMS Developed SSI Ratio Issued 3/16/12 CIRP Group:

By letter dated April 3, 2014, Toyon filed a Form B - Group Appeal Request to establish a Common Issue Related Party ("CIRP") group. The Proposed Group Name was SJHS 2008 Accuracy of CMS Developed SSI Ratio Issued 3/16/2012 CIRP Group. The Board acknowledged receipt of the CIRP group and assigned case number 14-3132GC.

As noted above, Toyon filed a Form D on April 4, 2014, transferring said issue from the appeal of Petaluma Valley Hospital, CN: 13-3174, to the subject CIRP group.

CASE NUMBER 14-3137GC - SJHS FY 2008 DSH Medicare Dual Elig Part C Days in SSI Ratio Issued 3/16/12 CIRP Group:

By letter dated April 3, 2014, Toyon filed a Form B - Group Appeal Request to establish a Common Issue Related Party ("CIRP") group. The Proposed Group Name was SJHS FY 2008 DSH Medicare Dual Eligible Part C Days in SSI Ratio Issued 3/16/2012 CIRP Group. The Board acknowledged receipt of the CIRP group and assigned case number 14-3137GC.

As noted above, Toyon filed a Form D on April 4, 2014, transferring said issue from the appeal of Petaluma Valley Hospital, CN: 13-3174, to the subject CIRP group.

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 issues stated above were previously transferred (from case number 13-3174) and are currently being pursued by the subject Provider in CIRP group appeals, case numbers 14-3132GC and 14-3137GC, the request to continue to pursue the subject issues in the newly formed individual appeal, case number 18-0361, 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 26, 2017 into the existing CIRP group appeals for the subject issues, case numbers 14-3132GC and 14-3137GC.

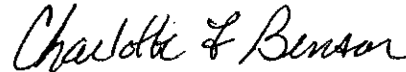
The Board notes that these were the only two (2) issues being disputed in case number 18-0361. Upon the transfer of the subject issues to CIRP group case numbers 14-3132GC and 14-3137GC, there are no further issues for the Board to adjudicate in the individual appeal, therefore, the Board hereby **closes** case number 18-0361.

Please note that when submitting the Schedule of Providers in CIRP group case numbers 14-3132GC and 14-3137GC, you must list the multiple final determinations in dispute for Petaluma Valley Hospital, Provider No.: 05-0136, FYE - 06/30/2008 and provide the supporting jurisdictional documents for each final determination in dispute. (See Board Rules 20 and 21.A.)

Board Members Participating:

Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Rob Evarts, Esq.

FOR THE BOARD:



Board Member

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUN 2 0 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**

13-0716GC CHS 2009 DSH Medicare + Choice Days CIRP Group

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 15, 2018, request for expedited judicial review (EJR) (received June 18, 2018) for the above-referenced appeal. The Board's determination is set forth below.

Issue in Dispute

The issue in this appeal is:

> [W]hether 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]

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)

---

[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]

---

[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*

---

[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

---

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

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeal in this EJR request have filed appeals involving fiscal year 2009.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[23] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[24]

On August 21, 2008, new regulations governing the Board were effective.[25] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell*

---

[23] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[24] *Bethesda at 1258-59.*
[25] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

(Banner).[26] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[27]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

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.[28] The Board notes that the sole participant appealing from a revised NPR in this EJR request was issued after August 21, 2008. The Board concludes that it lacks jurisdiction over the following Provider:

Participant #63: McKenzie Williamette Medical Center (38-0020)

McKenzie Williamette Medical Center appealed a revised NPR that did not revise the matter at issue as required for Board jurisdiction under 42 C.F.R. § 405.1889(b). Therefore, the Board hereby dismisses this Provider from the appeal. Since jurisdiction over a provider is a prerequisite to granting a request for EJR, the Board hereby denies McKenzie Williamette Medical Center's 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[29] 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.

---

[26] 201 F. Supp. 3d 131 (D.D.C. 2016)
[27] *Banner* at 142.
[28] See 42 C.F.R. § 405.1889(b)(1) (2008).
[29] *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request involves the fiscal year 2009, thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in 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 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

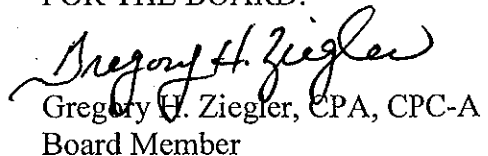
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

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 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 this case.

Board Members Participating

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

FOR THE BOARD:



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

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

cc: Byron Lamprecht, Wisconsin Physicians Service (Certified Mail w/Schedule of Providers)
Wilson Leong, Esq., 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

JUN 2 0 2018

Certified Mail

Isaac Blumberg
Blumberg Ribner, Inc.
315 Beverly Drive
Suite 505
Beverly Hills, CA 90212-1925

RE: **Expedited Judicial Review Determination**

14-4037G	Blumberg Ribner Independent Hospitals 2009 HMO Part C Days Group
15-0195G	Blumberg Ribner Independent Hospitals 2010 HMO Part C Days Group
15-2876G	Blumberg Ribner Independent Hospitals 2011 HMO Part C Days Medicaid Fraction Group II
15-2885G	Blumberg Ribner Independent Hospitals 2011 HMO Part C Days Medicare Fraction Group II

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's request for expedited judicial review (EJR) received June 8, 2018, for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

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

[1] Providers' EJR request at 1.

prospective payment system ("PPS").[2] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[9]
The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

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

[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).

> 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]

---

[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services.
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).

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

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[15]

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

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

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

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with

---

[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.

> the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

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

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

Providers' Request for EJR

The Providers assert that EJR is appropriate because the Secretary has not acquiesced to the decision in *Allina*. As a result, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effective as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). The Providers point out that they have met the timely filing requirements and the amount in controversy and believe that EJR is appropriate since the Board is bound by the regulation.

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

[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).

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 in this EJR request have filed appeals involving fiscal years 2009 through 2011.

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[21] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[22]

On August 21, 2008, new regulations governing the Board were effective.[23] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[24] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[25]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on or after December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item

[21] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[22] *Bethesda at 1258-59.*
[23] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[24] 201 F. Supp. 3d 131 (D.D.C. 2016)
[25] *Banner* at 142.

under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

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 self-disallowed the 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 appeals in this EJR request involve the 2009 through 2011 cost reporting periods, 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 Providers 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

---

[26] *See* 42 C.F.R. § 405.1837.

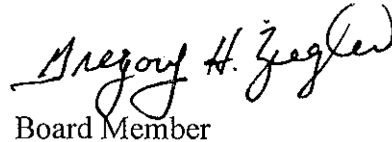
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since there are no other issues under dispute in these cases, the cases are hereby closed.

Board Members Participating:

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: Pam VanArsdale, NGS (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
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671

JUN 21 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**

14-0494GC CHS 2011 DSH SSI Fraction Part C Days Group
14-0495GC CHS 2011 DSH Medicaid Fraction Part C Days Group

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 8, 2018 requests for expedited judicial review (EJR) (received June 11, 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]

---

[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

---

[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]

---

[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 beneficiaries in the Medicaid fraction. Instead, we are*

---

[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.

> *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' Requests 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

---

[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.

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 2011.

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[23] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[24]

On August 21, 2008, new regulations governing the Board were effective.[25] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[26] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue.

---

[23] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[24] *Bethesda at 1258-59.*
[25] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[26] 201 F. Supp. 3d 131 (D.D.C. 2016)

The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[27]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on or after December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

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

<u>Board's Analysis Regarding the Appealed Issue</u>

The group appeals in this EJR request involves the 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.[29]

---

[27] *Banner* at 142.
[28] *See* 42 C.F.R. § 405.1837.
[29] On June 11, 2018, Wisconsin Physicians Service ("WPS") filed an objection to the EJR requests. 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.

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:

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: Byron Lamprecht, WPS (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
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671

JUN 21 2018

Certified Mail

Isaac Blumberg
Blumberg Ribner, Inc.
315 Beverly Drive
Suite 505
Beverly Hills, CA 90212-1925

RE: **Expedited Judicial Review Determination**

15-3227G	Blumberg Ribner Independent Hospitals 2012 HMO Part C Days - Medicare Fraction Group
15-3261G	Blumberg Ribner Independent Hospitals 2012 HMO Part C Days - Medicaid Fraction Group
16-1357G	Blumberg Ribner Independent Hospitals 2008 HMO Part C Days Medicaid Fraction Group II
16-1358G	Blumberg Ribner Independent Hospitals 2008 HMO Part C Days Medicare Fraction Group II

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's request for expedited judicial review (EJR) received June 8, 2018, for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

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

[1] Providers' EJR request at 1.

prospective payment system ("PPS").[2] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[9]
The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

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

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

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

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

---

[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services.
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).

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

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[15]

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

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

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

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with

---

[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.

> the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

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

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

Providers' Request for EJR

The Providers assert that EJR is appropriate because the Secretary has not acquiesced to the decision in *Allina*. As a result, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effective as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). The Providers point out that they have met the timely filing requirements and the amount in controversy and believe that EJR is appropriate since the Board is bound by the regulation.

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

---

[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).

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 participant in this EJR request have filed an appeal involving fiscal years 2008 and 2012.

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[21] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[22]

On August 21, 2008, new regulations governing the Board were effective.[23] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[24] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[25]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on or after December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item

[21] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[22] *Bethesda at 1258-59.*
[23] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[24] 201 F. Supp. 3d 131 (D.D.C. 2016)
[25] *Banner* at 142.

under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

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 self-disallowed the 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 appeal in this EJR request involve the 2008 and 2012 cost reporting periods, 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 Providers 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

[26] *See* 42 C.F.R. § 405.1837.

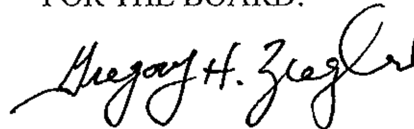
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since there are no other issues under dispute in these cases, the cases are hereby closed.

Board Members Participating:

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: Pam VanArsdale, NGS (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
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671

JUN 2 1 2018

CERTIFIED MAIL

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

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

RE: Houston Methodist Hospital Sugar Land
Provider No.: 45-0820
FYE: 12/31/10
PRRB Case No.: 15-1667

Dear Ms. Chi and Mr. Kamal,

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

Background

The Provider submitted a request for hearing on March 2, 2015, based on a Notice of Program Reimbursement ("NPR") dated September 3, 2014. The hearing request included seven issues:

1. Issue 1 – Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)[1]
2. Issue 2 – Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)
3. Issue 3 - Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") (Systemic Errors)
4. Issue 4 - Disproportionate Share Hospital Payment – Medicaid Eligible Days
5. Issue 5 - Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days[2]
6. Issue 6 - Disproportionate Share Hospital Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
7. Issue 7 – Whether Capital DSH was calculated correctly

The Provider subsequently submitted requests dated October 16, 2015 to transfer the following issues to group appeals:

[1] The Provider identifies SSI Ratio realignment to the Provider's cost reporting year as a sub-issue of Issue 1.
[2] Issue 5 consists of two parts – exclusion of the days from the Medicare fraction and inclusion of the days in the Medicaid fraction.

- Issue 3 to PRRB Case No. 15-2917GC – QRS Houston Methodist 2010 DSH SSI Percentage (Systemic Errors) CIRP Group
- Issue 5 (Medicare Fraction) to PRRB CN 15-2920GC – QRS Houston Methodist 2010 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Group
- Issue 5 (Medicaid Fraction) to PRRB Case No. 15-2921GC – QRS Houston Methodist 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group
- Issue 6 to PRRB CN 15-2918GC – QRS Houston Methodist 2010 DSH SSI Fraction Dual Eligible Days CIRP Group and PRRB CN 15-2919GC – QRS Houston Methodist 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group

The Medicare Contractor submitted a jurisdictional challenge on Issues #1, 2, and 4 on March 29, 2018. The Provider submitted a responsive brief on April 25, 2018.

Medicare Contractor's Position

Issue 1 and Issue 2 – Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)

The Medicare Contractor explains that in Issues 1 and 2, the Provider contends that the Medicare Contractor used the incorrect SSI percentage in processing its DSH payment. In Issue 3 the Provider contends that the Secretary improperly calculated its SSI percentage. The Provider is making the same argument, as the Medicare Contractor is required to use the SSI Ratio provided by CMS. Essentially, the Provider contends that the SSI ratio applied to its cost report was incorrect; the SSI ratio is the underlying dispute in both Issue 1 and Issue 3. The Provider transferred Issue 3 to PRRB Case Bo. 15-2917GC. Under Board Rules, the Provider is barred from filing a duplicate SSI percentage issue. Therefore, the PRRB should find that the SSI percentage is one issue for appeal purposes and that Issues 1 and 2 should be dismissed consistent with recent jurisdictional decisions[3]

Issue 1 includes the Provider's subsidiary appeal over SSI realignment. The Medicare Contractor contends that the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS 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.[4]

The Medicare Contractor argues that the Provider's appeal is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. §412.106(b)(3). The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The Medicare Contractor requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[5]

---

[3] Medicare Contractor's jurisdictional challenge at 1-2.
[4] Medicare Contractor's jurisdictional challenge at 2.
[5] Medicare Contractor's jurisdictional challenge at 2.

Issue 4 – Disproportionate Share Hospital Payment – Medicaid Eligible Days

The Medicare Contractor explains that the Provider cites adjustments 22, 23, and 24 as the source of its dissatisfaction. The Medicare Contractor contends that these adjustments do not render a final determination over the disputed days. The Provider fails to show how the disputed days were claimed on the cost report (or presented) and then disallowed by the Medicare Contractor. In the instant case, the Medicaid eligible days increased from the as filed to revised cost report. Logically, because they were not claimed by the Provider, the Medicare Contractor did not render a final determination over them.[6]

The Medicare Contractor argues that the Provider did not file its cost report under protest. Therefore, the Provider did not preserve 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). Under the 2008 regulation, the Medicare Contractor contends that that the Board lacks jurisdiction over the disputed days because they were neither claimed nor self-disallowed. In 2008, CMS amended 42 C.F.R. § 405.1811(a)(1) and 42 C.F.R. § 405.1835(a)(1) to require, as a condition to filing a valid appeal, the provider to have either claimed an item or included that item as a protested amount when filing its cost report.[7]

Provider's Position

Issue 1 and Issue 2 – Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)

The Provider contends that each of the appealed SSI issues are separate and distinct issues, and that the Board should find jurisdiction over this case. Board Rule 8.1 states that "Some issues may have multiple components. To comply with the regularity requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible..." Appeal issues #1 and #2 represent different components of the SSI issue, which was specifically adjusted during the audit. Since these specific appeal issues represent different aspects/components of the SSI issue, the Provider contends the Board should find jurisdiction over both the SSI Systemic and SSI Provider Specific/Realignment issues.[8]

The Provider contends that the SSI Systemic issue is not duplicative of the SSI Provider Specific issue. The Provider is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category. In Baystate,[9] the Board also considered whether, independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio. The Provider has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI. The Provider has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio. Therefore, the Board should find jurisdiction over the SSI

[6] Medicare Contractor's jurisdictional challenge at 3-5.
[7] Medicare Contractor's jurisdictional challenge at 8.
[8] Provider's responsive brief at 1.
[9] *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).

Provider Specific issue in the appeal.[10]

Accordingly, this is an appealable item because the Medicare Contractor specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2010, as a result of its understated SSI percentage due to errors of omission and commission. The Provider has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the *Baystate* litigation.[11]

Issue 4 – Disproportionate Share Hospital Payment – Medicaid Eligible Days

The Provider contends that in this case, there was in fact an adjustment to the Provider's DSH and Medicaid Eligible Days with Audit Adjustment Numbers 23 and 24, and such an adjustment was enough to warrant Board jurisdiction over this appeal issue. However, the Provider contends that the adjustment is not required, as DSH is not an item that has to be adjusted or claimed on a cost report. Accordingly, the presentment requirement is not valid. The Provider contends that the Board does have jurisdiction pursuant to Board Rule 7.2(B) and under the provisions of 42 U.S.C. § 1395oo(a)(1)(B). The issuance of a Notice of Program Reimbursement and timely appeal properly triggers the Board's jurisdiction over this Provider.[12]

In its Final Position Paper dated March 29, 2018, the Provider described a practical impediment that precluded the identification of all additional Medicaid Eligible Days at the time of cost report filing. The most common circumstance in which the State of Texas Medicaid agency is unable to verify Medicaid eligible days involves the retroactive eligibility situation. An individual's eligibility for Medicaid commences on the date of his/her application to the program, assuming that individual meets the eligibility qualifications for Medicaid at the time of application submission. However, there is frequently considerable lag time between the date on which an individual submits his/her application for Medicaid, and the date on which that individual is determined to be eligible for the program. This lag time typically involves several months, and in some cases, several years. In this circumstance, the State of Texas Medicaid agency will not have the data to verify an individual's eligibility for Medicaid as of the date of the Provider's filing of its Medicare cost report. It is beyond the Provider's ability to determine just why patient days or any particular patient day could not be matched by the State as eligible at one point in time (in this case, by the date of the cost report filing), but subsequently is matched as eligible by the State.[13]

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is

[10] Provider's responsive brief at 2.
[11] Provider's responsive brief at 2.
[12] Provider's responsive brief at 3.
[13] Provider's Final Position Paper at 4-5.

$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.....[14]

Issue 1 and Issue 2 – Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)

The staff finds that Board Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal. The Board has considered the DSH SSI Percentage - Provider Specific and DSH SSI Percentage - Systemic Errors issues to be the same issue as both are based on SSI data. As such, the issue cannot be in two cases at the same time. Therefore, the Board should find that it does not have jurisdiction over Issue 1 and Issue 2 – DSH SSI Percentage - Provider Specific, and dismiss them from the appeal, as they are the same issue that the Provider is appealing in PRRB Case No. 15-2917GC - QRS Houston Methodist 2010 DSH SSI Percentage (Systemic Errors) CIRP Group.

Whereas the Provider states that SSI Ratio Realignment is a sub-issue of Issue 1, the Board should find 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 dismiss it 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.

Issue 4 – Disproportionate Share Hospital Payment – Medicaid Eligible Days

The first step in the analysis involves the appeal's filing date and cost reporting period. On March 2, 2015, the Board received Houston Methodist's Request for Hearing concerning its FYE 12/3/2010 cost reporting period, thus mandates set out in Ruling CMS-1727-R apply to Houston Methodist's instant appeal.

Second, the Board must determine whether the appealed item "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider.[15]

---

[14] 42 C.F.R. § 405.1835(a).
[15] CMS-1727-R at unnumbered page 6.

Under Sections 1815(a) and 1833(e) of the Social Security Act, no Medicare payments are made to a provider unless the provider has furnished information requested by the Secretary so that the Secretary may determine the amount of payment due. With respect to a hospital's Medicare DSH payment – comprised of the Medicare and Medicaid fractions, part of the Secretary's regulations mandate that a DSH-eligible hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[16]

In the instant appeal, Houston Methodist argues that it was unable to include all of its Medicaid eligible days on its cost report because the documentation to verify all of the days was not available at the time that Houston Methodist was required to submit its information. The stated most common circumstance in which the State of Texas Medicaid agency is unable to verify Medicaid eligible days involves the retroactive eligibility situation. The Provider states the lag time between the date on which an individual submits his/her application for Medicaid, and the date on which that individual is determined to be eligible for the program causes claims delays. This lag time typically involves several months, and in some cases, several years. In this circumstance, the State of Texas Medicaid agency will not have the data to verify an individual's eligibility for Medicaid as of the date of the Provider's filing of its Medicare cost report. It is beyond the Provider's ability to determine just why patient days or any particular patient day could not be matched by the State as eligible at one point in time (in this case, by the date of the cost report filing), but subsequently is matched as eligible by the State.[17]

As the pertinent DSH regulations instruct that a provider is required to furnish Medicaid patient verification information to the Medicare contractor, and because the time frame within which a hospital must file its cost report is also set by regulation, the Board finds that Houston Methodist's Medicaid eligible day issue "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider." In other words, Houston Methodist's issue meets the requirements of the second step in CMS-1727-R.

The third, fourth and fifth steps in CMS-1727-R's analysis involves the Board's assessment of whether a provider's appeal has met the jurisdictional requirements set out in the applicable regulation.[18] As Houston Methodist's appeal was timely filed and Houston Methodist estimates that its amount in controversy is over $10,000, the first two Board' jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, CMS -1727-R sets out three different scenarios – in steps three, four and five – for the Board to consider.

The Board looks to step three if it is reviewing an appealed item which was, in fact, within the payment authority or discretion of the Medicare contractor, i.e. an "allowable" item. In the instant appeal, Houston Methodist's Medicaid eligible days were not within the payment authority or discretion of the Medicare contractor because Houston Methodist had not verified the days at the time that it filed its cost report, as explained above.

[16] 42 C.F.R. § 412.106(b)(4)(iii) (2010).
[17] Provider's Final Position Paper at 4-5.
[18] 42 C.F.R. § 405.1835(a) (2010).

The Board looks to step four if it is reviewing an appealed item that was deemed "non-allowable." Under the Board's jurisdictional regulation, a provider who seeks payment that it believes is not in accordance with Medicare policy, i.e., a non-allowable item, must self-disallow the item by filing its cost report under protest. However, under CMS-1727-R, if the Board finds that the appealed item was subject to a regulation or other payment policy that bound the Medicare contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, then the Board shall not apply the self-disallowance jurisdictional regulation. In the instant appeal, under the analysis for CMS-1727-R's step two, Houston Methodist's appealed Medicaid eligible days appear to be subject to a regulation that bound the Medicare contractor such that it had no discretion or authority to make payment as sought by Houston Methodist. Therefore, under the terms of CMS-1727-R, the Board "shall not apply the self-disallowance jurisdiction regulation" to Houston Methodist's Medicaid eligible days issue when considering whether the issue meets the "dissatisfaction" jurisdictional requirement of 42 C.F.R. § 405.1835(a).

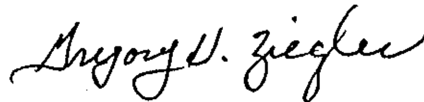
Under CMS-1727-R's fifth step, the Board may still consider the circumstances surrounding a provider's self-disallowance claim. In the instant appeal, however, Houston Methodist did not self-disallow its Medicaid eligible days issue, thus this step is not applicable to this appeal.

Despite the fact that Houston Methodist did not claim or protest its appealed Medicaid eligible days, based on the five-step analysis set out in CMS-1727-R, the Board concludes that to the extent that Houston Methodist's Medicaid eligible days under appeal were not able to be verified prior to the cost report filing date, the Board has jurisdiction under CMS-1727-R. Without the actual listing of days being requested, the Board cannot verify that each and every day was verified after the cost report was submitted, but to the extent that they were, the Provider was barred from claiming those days on the as-filed cost report for payment. It is the responsibility of both Houston Methodist and the Medicare contractor, based on information privy to those two parties, to ascertain the Medicaid eligible days that are subject to the Board's jurisdiction.

This case is scheduled for a live hearing on July 12, 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:
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) and 42 C.F.R. §§ 405.1875 and 405.1877

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

JUN 2 1 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 Group II, CN 17-1885G
Specifically:
Marin General Hospital, 05-0360, FYE 12/31/2012, CN 17-0595
Arrowhead Regional Medical Center, 05-0245, FYE 6/30/2012, CN 18-1172

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 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 Board's jurisdictional determination is set forth below:

Board Determination:

Although the Medicare Contractor only challenged the Board's jurisdiction over the SSI Provider Specific issue (to which HRS submitted a responsive jurisdictional brief) in case number 17-0595, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue for either of the above-referenced Providers.

One of the issues in case numbers 17-0595 and 18-1172 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, or transferred the issue, into the optional group, case number 17-1885G.

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 17-1885G and this aspect is hereby dismissed by the Board.[1]

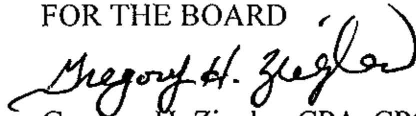
[1] Other than its assertion that the SSI Provider Specific issue is separate and distinct, the Representative has not provided any documentation or details to distinguish the issue from the Systemic SSI issue already pending in the group.

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 other issues pending in both individual appeals, the cases will remain open. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the cases on the merits.

Board Members:
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)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUN 2 2 2018

CERTIFIED MAIL

Quality Reimbursement Services, Inc.
David L. Cohan
150 North Santa Anita Avenue
Suite 570A
Arcadia, CA 91006

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

RE: Christian Hospital Northeast
Provider No. 26-0180
FYE 12/31/2010
PRRB Case No. 15-1720

Dear Mr. Cohan and Mr. Lamprecht,

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

Christian Hospital Northeast is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in an Original Notice of Program Reimbursement (NPR) dated September 9, 2014. The Provider filed a timely appeal from the NPR on March 6, 2015. The Model Form A- Individual Appeal Request, Tab 3, presented two issues: SSI Provider Specific and Medicaid eligible days. The Provider later requested to withdraw the Medicaid Eligible Days issue. On March 9, 2015, the Provider requested to directly add the SSI Systemic Errors issue to case no. 15-0646GC. The only remaining issue in the appeal is the SSI Provider Specific issue. The Medicare Contractor has challenged jurisdiction over the SSI Provider Specific issue.

Medicare Contractor's Position

The Medicare Contractor argues that the Board does not have jurisdiction over the SSI Provider Specific issue because the Provider only wants to change its election of the fiscal year end for the SSI percentage of the DSH computation. The Medicare Contractor asserts that the realignment portion of the Provider's issue should be dismissed because there has been no final determination over the realignment and the appeal is premature as the Provider has not exhausted all available remedies.

Provider's Position:

The Provider contends that Medicare Contractor is incorrect when arguing that the DSH/SSI realignment issue is not an appealable issue.[1] The Provider states that the Provider is addressing not only a realignment of the SSI percentage but also addressing various errors of omission and commission that do not fit into the "systemic errors" category. Thus, the Provider argues that this is an appealable item because the Medicare Contractor specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year end ("FYE") as a result of its understated SSI percentage.[2]

Further, the Provider asserts that in *Northeast Hospital Corporation v. Sebelius*, the Centers for Medicare and Medicaid Services ("CMS") abandoned the CMS Administrator's December 1, 2008 decision. 657 F.3d 1 (D.C. Cir. 2011). The decision here that was abandoned was that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS. Thus, the Provider reasons that the Provider can submit data to prove its SSI percentage was understated.[2] However, the Provider mentions that, to this point, the Provider has been unable to submit such data because CMS has not released the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") data—HHS/HCFA/OIS, 09-07-009, published in the Federal Register on August 18, 2000—in support of the SSI percentage.[3]

The Provider contends that CMS has just now started releasing the MEDPAR data, but the Provider has not yet received its MEDPAR data and has been unable to reconcile its records with that of CMS. The Provider argues that it is unable to specifically identify patients believed to be entitled both to Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal FYE (September 30) when it determined the Provider's SSI percentage. The Provider states that though the Provider may choose to request realignment, this still will not correct these errors of omission and commission that are understating the Provider's SSI percentage. Therefore, the Provider requests that the Board finds that it has jurisdiction over the DSH/SSI "provider specific" and realignment sub-issues.[4]

Board's Decision

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

The first aspect of the SSI Provider Specific issue—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was transferred to a group and is

---

[1] *See* Provider's Jurisdictional Response at 1.
[2] *Id.*
[3] *Id.* (citing 65 Fed. Reg. 50, 548 (2000)).
[4] *Id.*

dismissed by the Board.[5] 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."[6] 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)."[7] 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."[8]

The Provider's Systemic Errors issue is "[whether] the Secretary properly calculated the Provider's Disproportionate Share Hospital/Supplemental Security Income percentage." 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 the SSI Provider Specific issue.

The second aspect of the issue—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.

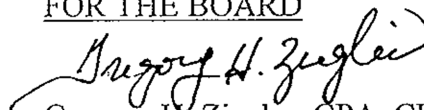
Conclusion

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue in case no. 15-1720 and dismisses the issue from the appeal. As this was the last issue in the appeal, PRRB Case No. 15-1720 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:
Gregory H. Ziegler, CPA, CPC-A
Charlotte F. Benson, CPA
Robert Evarts, Esq.

FOR THE BOARD



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

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

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

JUN 2 5 2018

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

RE: Supplemental Determination Denying Requests to Transfer to Group
Lehigh Regional Medical Center, 10-0107, 12/31/2009, CN 17-2218
Dallas Regional Medical Center, 45-0688, 12/31/2009, 17-2288

Dear Mr. Summar:

On June 22, 2018, the Provider Reimbursement Review Board (the Board) issued a jurisdictional determination which included the above-captioned individual appeals. The Board's determination found that it did not have jurisdiction over the SSI Provider Specific and SSI Ratio (Systemic errors) issues appealed from the RNPRs because the specific issues were not adjusted as part of the RNPRs. Additionally, the Board found that the Providers had received a realigned SSI percentage as they had requested so there was nothing with which the Providers could be dissatisfied.

Because the Board does not have jurisdiction over the SSI Provider Specific and SSI Ratio (Systemic errors/Baystate) issues appealed from the RNPRs, it also denies the subject Providers' requests to transfer the SSI Percentage issues as follows:

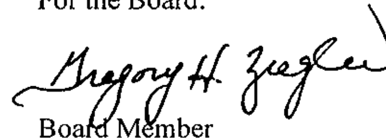
From Case No.	To Group
17-2218	13-2319GC
17-2288	13-2319GC

These transfer denials were omitted from the June 22, 2018 determination. Please adjust your records accordingly. The individual appeals are hereby closed as there are no remaining issues.

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

Board Members Participating:
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) and 42 C.F.R. §§ 405.1875 and .1877

cc: James Ravindran, Quality Reimbursement Services (CERTIFIED MAIL)
Byron Lamprecht, Wisconsin Physicians Service
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Certified Mail

JUN 28 2018

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

RE: **Expedited Judicial Review Determination**
13-1505GC Premier Health Partners 2008 Medicare/Medicaid Medicare Advantage Days CIRP
13-2093GC McLaren Health Care 2008 Medicare/Medicaid Medicare Advantage Days CIRP
13-2623GC Community Healthcare System 2008 Medicare/Medicaid Part C Days CIRP
14-0737GC Good Shepherd Health System 2008 DSH Medicare/Medicaid Part C Days CIRP
14-0866GC WakeMed 2008 Medicare/Medicaid Part C Days CIRP
17-1239G Hall Render 2007 DSH Medicare/Medicaid Medicare Part C Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 19, 2018 request for expedited judicial review (EJR) (received June 20, 2018).[1] The Board's determination is set forth below.

Issue

The issue for which EJR has been requested is:

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

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]

---

[1] Although the EJR request was received June 20, 2018, the exhibits attached to the request were incorrect. The Representative prepared correction letters and resubmitted the corrected exhibits to the Board on June 21, 2018.
[2] EJR Request at 2.
[3] *See* 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.
[4] *Id.*

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

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

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

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

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

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

> 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

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

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

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

Medicare Advantage Program

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

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

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

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

---

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

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

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

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

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

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

---

[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.

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

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

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

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

<u>Providers' Request for EJR</u>

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

---

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

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

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

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

Decision of the Board

Board's Authority

Under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2016), the Board is required to grant 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 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

[25] *Id.*
[26] *Id.*
[27] *Id.* at 7

determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[28]

All of the participants in Case Nos. 13-1505GC, 13-2623GC, 14-0737GC and 14-0866GC filed appeals of their original notices of program reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending from 6/30/2008 through 12/31/2008. The participants in Case No. 13-2093GC have a 9/30/2008 cost period, but the group includes one participant that appealed from a revised NPR. The participants in Case No. 17-1239G all appealed cost reporting periods ending in 2007. Five of the nine participants in this group appealed from revised NPRs.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[29] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[30]

On August 21, 2008, new regulations governing the Board were effective.[31] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[32] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could

---

[28] The regulations governing Board jurisdiction begin at 42 C.F.R. § 405.1835. These regulations are essentially the same for the years covered by the appeals involved with the instant EJR request except for the sub-clause regarding timely filing. For appeals filed prior to August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date the notice of the Medicare contractor's determination was mailed to the provider. 42 C.F.R. § 405.1841(a) (2007). For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

[29] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

[30] *Bethesda at 1258-59.*

[31] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

[32] 201 F. Supp. 3d 131 (D.D.C. 2016)

not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[33]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

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 the participants appealing from revised NPRs in this EJR request were all issued after August 21, 2008.

The Board concludes that it lacks jurisdiction over the following Provider in Case No. 13-2093GC:

Participant #1-- McLaren Flint

McLaren Flint timely filed directly into the group from a May 15, 2014 revised NPR. The Provider referenced audit adjustment #5 which was an adjustment to include additional Medicaid days to be included in the DSH calculation. Since the adjustment appealed did not adjust Medicare Part C days, as required for jurisdiction over the appeal, the Board finds that it lacks jurisdiction over this participant in the group and hereby dismisses McLaren Flint from the appeal. Since jurisdiction over a provider is a prerequisite to granting a request for EJR, the Board hereby denies McLaren Flint's 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[35] 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.

---

[33] *Banner* at 142.
[34] See 42 C.F.R. § 405.1889(b)(1) (2008).
[35] *See* 42 C.F.R. § 405.1837.

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

The Providers within this EJR request filed appeals cost reporting periods in 2007 and 2008, thus the cost reporting periods fall squarely within the time frame that covers the Secretary's final rule being challenged.[36] 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.[37]

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 except as otherwise noted above;

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

---

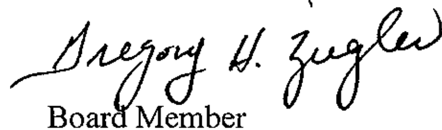
[36] As stated in the FY 2014 IPPS Final Rule, the Secretary "proposed to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP[,]" thus "sought public comments from interested parties . . ." following publication of the FY 2014 IPPS Proposed Rule, 78 Fed. Reg. 27578 (May 10, 2013). Ultimately, the Secretary finalized this DSH policy for FFY 2014 and subsequent years on August 19, 2013, in the FY 2014 IPPS Final Rule. *See* 78 Fed. Reg. 50496, 50615 (Aug. 19, 2013). The Provider appeals in the instant EJR request are all based upon FY 2013 cost reporting periods and earlier.
[37] *See* 863 Fed. 3d 937 (D.C. Cir. 2017).

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 numbers 13-1505GC, 13-2093GC, 13-2623GC, 14-0737GC, 14-0866GC, 17-1239G.

Board Members Participating:

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)
Schedule of Providers

Certified Mail w/Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUN 2 8 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**
CHS 2007 DSH Medicare+Choice Days CIRP Group, Case No. 13-0095GC

Dear Mr. Hettich:

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

Issue in Dispute

The issue in this appeal 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]

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)

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]

---

[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).
[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

---

[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.

---

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

---

[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.

Jurisdictional Determination

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

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[23] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[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 all 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 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 the case.

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request is for 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

[23] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[24] *Bethesda at 1258-59.*
[25] See 42 C.F.R. § 405.1889(b)(1) (2008).
[26] *See* 42 C.F.R. § 405.1837.

and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

Board Members Participating:
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)
Schedule of Providers

cc: Byron Lamprecht, Wisconsin Physicians Service (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
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671

JUN 2 8 2018

Certified Mail

Michael G. Newell
Southwest Consulting Associates
2805 Dallas Parkway
Suite 620
Plano, TX 75093-8724

RE: **Expedited Judicial Review Determination**
17-1366G Southwest Consulting 2013 DSH SSI Fraction Part C Days Group II
17-1367G Southwest Consulting 2013 DSH Medicaid Fraction Part C Days Group II
17-1442G Southwest Consulting 2009-2010 DSH Medicaid Fraction Part C Days Group II
17-1529G Southwest Consulting 2009-2010 DSH SSI Fraction Part C Days Group II

Dear Mr. Newell:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 18, 2018 request for expedited judicial review (EJR) (received June 20, 2018) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these appeals is:

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

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

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)

---

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

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

Medicare Advantage Program

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

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

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

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

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

[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

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.

<u>Providers' Request for EJR</u>

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).

---

[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.

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 2009-2010 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.*[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 the participants that filed from revised NPR appeals included within this EJR request were all issued after August 21, 2008.

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

Revised NPRs for SSI Realignment appeals

Case No. 17-1529G: Provider # 1- Santa Barbara Cottage Hospital; # 7- The Chambersburg Hospital; #8 Virginia Baptist Hospital Lynchburg

Case No. 17-1366G: Provider # 1- UAMS Medical Center

and Case No. 17-1442G : Provider #6 - Virginia Baptist Hospital Lynchburg

These Providers filed appeals from revised NPRs that were issued as a result of the Providers' requests for realignment (that their SSI percentages be recalculated from the federal fiscal year to their cost reporting year.) CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used. The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI%) and reports it on the provider's cost reporting period instead of the 9/30 FFY. Thus, these participants are not challenging that the Medicare Contractor or CMS calculated the realigned SSI ratio incorrectly, i.e. did not use the right patients for those dates. Instead, they are challenging whether Medicare Part C patients are entitled to benefits under Part A, such that they should be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator, or vice-versa. Because the RNPRs did not adjust the SSI/Part C days issue as required for Board jurisdiction under 42 C.F.R. § 405.1889(b), the Board finds that it lacks jurisdiction over participant #1, #7 and #8 in case number 17-1529G; participant #1 in case number 17-1366G and participant #6 in case number 17-1442G and hereby dismisses them from the appeals. Since jurisdiction over a Provider is a prerequisite to granting a request for EJR, the Board denies the requests for EJR for these participants as well. *See* 42 C.F.R. § 405.1842(a).

Revised NPRs

Case 17-1529G: Provider #5- St. Luke's Hospital

Case 17-1442G: Provider #4- St. Luke's Hospital

This Provider filed its appeal from a revised NPR that did not adjust the SSI/Part C days issue as required for Board jurisdiction under 42 C.F.R. § 405.1889(b). In both cases, the Provider referenced audit adjustment 7 which adjusted MA (eligible) days to the audited total for use in the DSH calculation. The adjustment was made to Worksheet S-3. The Provider also referenced audit adjustment 8 which adjusted allowable DSH on Worksheet E, Part A. Consequently, the Board does not have jurisdiction over the appeal of St. Luke's Hospital's Part C days issue and hereby dismisses the Provider from both 17-1529G and 17-1442G, as it is a participant in both cases.

Since jurisdiction over a Provider is a prerequisite to granting a request for EJR, the Board denies St. Luke's Hospital's request for EJR. *See* 42 C.F.R. § 405.1842(a).

The Board has determined that all participants in case number 17-1367G and the remaining participants in case numbers 17-1529G, 17-1366G and 17-1442G 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 its respective appeal. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal and the remaining participants' 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 involve the fiscal years 2009-2010 and 2013, 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 remaining participants in the 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

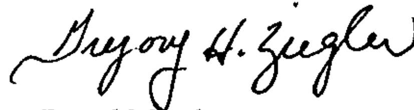
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

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 remaining Provider's requests 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 the cases.

Board Members Participating:

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

(Certified Mail w/Schedules)
cc: Pam VanArsdale, National Government Services, Inc.
Laurie Polson, Palmetto GBA c/o National Government Services
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUN 28 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**
CHS Post 10/1/2004 DSH Medicare + Choice Days CIRP Group, Case No. 08-2551GC

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 20, 2018 request for expedited judicial review (EJR) (received June 21, 2018) for the above-referenced appeal. The Board's determination is set forth below.

Issue in Dispute

The issue in this appeal is:

> [W]hether 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]

---

[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

---

[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).

> 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]

---

[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 beneficiaries in the Medicaid fraction. Instead, we are*

[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.

> *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' Requests 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

---

[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.

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 appeal in this EJR request have filed appeals involving fiscal year 2005.

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[23] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[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 the participants that filed from revised NPR appeals included within this EJR request were all issued after August 21, 2008.

[23] 108 S. Ct. 1255 (1988).
[24] *Bethesda at 1258-59.*
[25] See 42 C.F.R. § 405.1889(b)(1) (2008).

Provider #6- Hillcrest Hospital, Claremore (37-0039) FYE 10/31/2005

This Provider filed its appeal from a revised NPR dated February 14, 2013. The revised NPR did not adjust the SSI/Part C days issue as required for Board jurisdiction under 42 C.F.R. § 405.1889(b). The Provider referenced audit adjustment 5 which adjusted total Medicaid eligible days and the allowable DSH percentage per an Administrative Resolution agreement. Consequently, the Board finds that it does not have jurisdiction over the appeal of Hillcrest Hospital, Claremore's Part C days issue and hereby dismisses the Provider from case number 08-2551GC. Since jurisdiction over a Provider is a prerequisite to granting a request for EJR, the Board denies Hillcrest Hospital, Claremore's request for EJR. *See* 42 C.F.R. § 405.1842(a).

The Board has determined that the remaining participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. 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 appeal in this EJR request involves the fiscal year 2005 (Post 10/1/2004), thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in this request. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed,* No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

[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 year and that the remaining participants in this group appeal are entitled to a hearing before the Board;

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

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

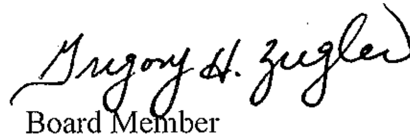
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

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

Board Members Participating:

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: Byron Lamprecht, WPS (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
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671

JUN 28 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**

ProMedica Health System 2006 DSH Medicare/Medicaid Medicare Advantage Days CIRP Group, Case No. 13-2212GC

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 22, 2018 request for expedited judicial review (EJR) (received June 25, 2018) for the above-referenced appeal. The Board's determination is set forth below.

Issue in Dispute

The issue in this appeals is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[9]
The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

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

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]

---

[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).
[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

---

[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.

---

[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. The Secretary has not acquiesced to that decision.

Providers' Request for EJR

In this case, the Providers are dissatisfied with the final determination of the Secretary as to the amount of payment under 42 U.S.C. § 1395ww(d); 42 U.S.C. § 1395oo(a)(1)(A)(ii); and 42 C.F.R. § 412.106. Specifically, the Providers are dissatisfied with the Secretary's allegedly erroneous inclusion of Part C days in both the numerator and denominator of the Medicare fraction. Further, the Secretary's failure to include any Part C days in the numerator of the Medicaid fraction, even when a patient was dual-eligible, i.e., was eligible for Medicaid as well as Medicare, understated the Medicaid fraction and caused financial losses for the Providers.

The Providers believe that the Secretary's interpretation and regulation are substantively and procedurally defective. They believe that Part C days should not be included within the Medicare fraction because those beneficiaries are not entitled to benefits under Part C, and the Secretary's regulation is invalid because it was promulgated in violation of both the Administrative Procedures Act and the Medicare Act, as upheld by the Federal Courts in *Allina.* The Providers assert that the days for dual-eligible Part C beneficiaries should be counted in the numerator of the Medicaid fraction and the Secretary's failure to do so resulted in underpayment to the Providers of their DSH adjustment, including capital DSH.

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 12/31/2006.

---

[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[21] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[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 of the participants in this group are appealing from revised NPRs and all 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 self-disallowed the 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 appeal in this EJR request is for fiscal year 12/31/2006, 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.

---

[21] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

[22] *Bethesda at 1258-59.*

[23] See 42 C.F.R. § 405.1889(b)(1) (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 this group appeal are entitled to a hearing before the Board;

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

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

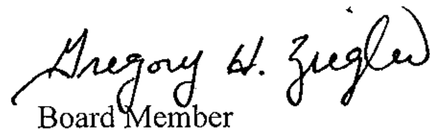
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

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

Board Members Participating:

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: 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

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

JUN 2 8 2018

Certified Mail

Michael G. Newell
Southwest Consulting Associates
2805 Dallas Parkway
Suite 620
Plano, TX 75093-8724

RE: **Expedited Judicial Review Determination**
17-1366G Southwest Consulting 2013 DSH SSI Fraction Part C Days Group II
17-1367G Southwest Consulting 2013 DSH Medicaid Fraction Part C Days Group II
17-1442G Southwest Consulting 2009-2010 DSH Medicaid Fraction Part C Days Group II
17-1529G Southwest Consulting 2009-2010 DSH SSI Fraction Part C Days Group II

Dear Mr. Newell:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 18, 2018 request for expedited judicial review (EJR) (received June 20, 2018) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these appeals is:

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

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

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)

---

[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

---

[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

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.

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).

---

[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.

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 2009-2010 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.*[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 the participants that filed from revised NPR appeals included within this EJR request were all issued after August 21, 2008.

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

Revised NPRs for SSI Realignment appeals

Case No. 17-1529G: Provider # 1- Santa Barbara Cottage Hospital; # 7- The Chambersburg Hospital; #8 Virginia Baptist Hospital Lynchburg

Case No. 17-1366G: Provider # 1- UAMS Medical Center

and Case No. 17-1442G : Provider #6 - Virginia Baptist Hospital Lynchburg

These Providers filed appeals from revised NPRs that were issued as a result of the Providers' requests for realignment (that their SSI percentages be recalculated from the federal fiscal year to their cost reporting year.) CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used. The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI%) and reports it on the provider's cost reporting period instead of the 9/30 FFY. Thus, these participants are not challenging that the Medicare Contractor or CMS calculated the realigned SSI ratio incorrectly, i.e. did not use the right patients for those dates. Instead, they are challenging whether Medicare Part C patients are entitled to benefits under Part A, such that they should be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator, or vice-versa. Because the RNPRs did not adjust the SSI/Part C days issue as required for Board jurisdiction under 42 C.F.R. § 405.1889(b), the Board finds that it lacks jurisdiction over participant #1, #7 and #8 in case number 17-1529G; participant #1 in case number 17-1366G and participant #6 in case number 17-1442G and hereby dismisses them from the appeals. Since jurisdiction over a Provider is a prerequisite to granting a request for EJR, the Board denies the requests for EJR for these participants as well. *See* 42 C.F.R. § 405.1842(a).

Revised NPRs

Case 17-1529G: Provider #5- St. Luke's Hospital

Case 17-1442G: Provider #4- St. Luke's Hospital

This Provider filed its appeal from a revised NPR that did not adjust the SSI/Part C days issue as required for Board jurisdiction under 42 C.F.R. § 405.1889(b). In both cases, the Provider referenced audit adjustment 7 which adjusted MA (eligible) days to the audited total for use in the DSH calculation. The adjustment was made to Worksheet S-3. The Provider also referenced audit adjustment 8 which adjusted allowable DSH on Worksheet E, Part A. Consequently, the Board does not have jurisdiction over the appeal of St. Luke's Hospital's Part C days issue and hereby dismisses the Provider from both 17-1529G and 17-1442G, as it is a participant in both cases.

Since jurisdiction over a Provider is a prerequisite to granting a request for EJR, the Board denies St. Luke's Hospital's request for EJR. *See* 42 C.F.R. § 405.1842(a).

The Board has determined that all participants in case number 17-1367G and the remaining participants in case numbers 17-1529G, 17-1366G and 17-1442G 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 its respective appeal. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal and the remaining participants' 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 involve the fiscal years 2009-2010 and 2013, 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 remaining participants in the 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 remaining Provider's requests 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 the cases.

Board Members Participating:

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

(Certified Mail w/Schedules)
cc: Pam VanArsdale, National Government Services, Inc.
Laurie Polson, Palmetto GBA c/o National Government Services
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUN 2 8 2018

CERTIFIED MAIL

Toyon Associates, Inc.
Thomas P. Knight, CPA
President
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

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

RE: Request for Reconsideration of Bifurcation and Jurisdictional Determination for CHW 1997 DSH Dual Eligible Days CIRP Group and Mercy General Hospital
PRRB Case No.: 06-0032GC

Dear Mr. Knight and Ms. Frewert:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the CHW 1997 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's ("CHW") request that the Board reconsider its December 31, 2015 Decision denying jurisdiction over Mercy General Medical Center, prov. no. 05-0017, and excluding the Provider from the newly established dual eligible Part C Days Group, case no. 16-0497GC.

Background

On December 31, 2015, the Board issued a decision in which it denied jurisdiction over several participants in case no. 06-0032GC, including Mercy General Medical Center, prov. no. 05-0017. The Board also granted the Providers' request for bifurcation of the dual eligible Part A and Part C days issues for all jurisdictionally valid Providers and established case no. 16-0497GC for the Part C/HMO days issue.

On February 24, 2016, the group representative, Toyon Associates, Inc. ("Toyon") submitted a reconsideration request in which it has asked the Board to reconsider its decision to deny jurisdiction over Mercy General Medical Center. In its December 31, 2015 decision, the Board found that the Provider did not properly transfer the dual eligible days issue to case no. 06-0032GC and therefore denied jurisdiction and bifurcation of the issues for the Provider.

Facts – Mercy General Medical Center

PRRB Case No. 06-0032GC was established with the Board on October 14, 2005 with the following issue statement:

> Whether the Medicaid Ratio used to calculate Medicare Disproportionate Share Payments (DSH) accurately reflects the number of patient days furnished to all patients eligible for Medicaid in situation where the patient is also enrolled in the Medicare Part A Program but is not entitled to Medicare Part A benefits.
>
> We contend that the number of Medicaid eligible patient days used in the DSH calculation are understated due to exclusion of various categories of Medicaid eligible patients who enrolled in Medicare Part A but are not entitled to Medicare Part A benefits. The applicable regulation governing this issue is 42 C.F.R. § 412.106.[1]

Mercy Medical Center filed its individual appeal request with the Board on October 25, 2006. The Provider included the dual eligible days issue in its appeal request with the following language:

> The Provider believes that certain dual eligible Medicare/Medicaid patient days should have been included in the disproportionate share entitlement calculation. The patient days pertaining to Medicaid eligible patients whose Part A benefits were exhausted or were enrolled in a Medicare HMO or had no Medicare Part A paid claim should be included in the Medicaid eligible days used to calculate the disproportionate share amount. These days should be included because they are excluded from the calculation of the Medicare SSI ratio. **42 CFR § 412.106.**
>
> Estimated reimbursement effect is $154,000. This issue is being transferred to the following group appeal: CHW 1997 DSH Dual Eligible Days Group, PRRB Case No. 06-0032G . . .[2]

In a letter dated December 31, 2015, the Board issued a decision in which it denied jurisdiction over several Providers in case no. 06-0032GC and in which it granted bifurcation of the dual eligible Part A and Part C days issues for jurisdictionally valid Providers. In that letter the Board found that it did not have jurisdiction over Mercy General Medical Center, prov. no. 05-0017, based on the rationale that the Provider did not properly transfer the dual eligible days issue from its individual appeal to case no. 06-0032GC. This decision was based on a transfer letter included in the record that requested to transfer the dual eligible days issue for Mercy General to a different group appeal.[3]

BOARD'S DECISION

The Board grants the request for reconsideration of its previous decision and determines that it has jurisdiction over Mercy General Medical Center as a participant in case no. 06-0032GC. The Board also grants bifurcation of the dual eligible Part A and HMO issues for this Provider, and transfers the HMO issue to case no. 16-0497GC. Case no. 06-0032GC is hereby reopened in

[1] Administrative Record at 722.
[2] Administrative Record at 91.
[3] Administrative Record at 113.

order to address jurisdiction and bifurcation of the dual eligible days issues for Mercy General Medical Center, provider no. 05-0017.

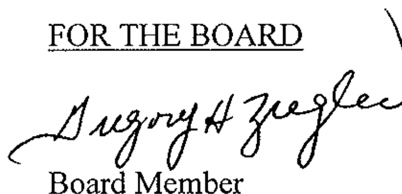
The Board finds that the Provider properly requested to transfer the dual eligible days issue to case no. 06-0032GC in its individual appeal request, therefore the Board has jurisdiction over the Provider.

This Provider is appealing from fiscal year end ("FYE") 1997, therefore this fiscal year was prior to the 2004 final rule discussing how to count HMO or Part C days.[4] Further, the 2004 proposed rule indicates that Part C days were included in the Medicaid fraction pre-2004.[5] Based on this, the Board finds that the Provider appealed both the dual eligible and Part C/HMO days issues. The Board hereby transfers the HMO days issue to case no. 16-0497GC, CHW 1997 HMO Days CIRP Group. Remand of Mercy General Medical Center pursuant to CMS Ruling 1498-R will be addressed under separate cover.

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
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A
Robert Evarts, Esq.

FOR THE BOARD



Board Member

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

cc: Wilson Leong, CPA, Esq. Federal Specialized Services

[4] 69 Fed. Reg. 48916 (Aug. 11, 2004).
[5] *See Allina Health Servs. V. Sebelius*, 746 F.3d 1102, 1106 (D.C. Cir. 2014) (citing to *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 16-17 (D.C. Cir. 2011)).