DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL AUG 01 2018

Besler Consulting
Dana Aylward
Senior Consultant
3 Independence Way, Suite 201
Princeton, NJ 08540-6626

RE: St. Joseph's Regional Medical Center
Provider No: 31-0019
FYE: 12/31/2012
PRRB Case No: 18-1482

Dear Ms. Aylward:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's July 17, 2018 request for hearing which was received (filed)[1] by the Board on July 18, 2018. The Board's jurisdictional determination is set forth below.

The Code of Federal Regulations provides for a right to hearing based on an untimely contractor determination. The definition of untimely is explained by 42 C.F.R. § 405.1835(c)(1) (2015), which states:

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.

Furthermore, 42 C.F.R. § 405.1835(c)(2) (2015) explains the timeframe in which the provider is able to file an appeal from an untimely determination:

> (2) Unless the provider qualifies for a good cause extension under

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

> § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section).

Decision of the Board

In this case, the Provider's cost report was received by the Medicare Contractor on May 31, 2013. The expiration of the 12 month period for issuance of the final contractor determination was May 31, 2014. Pursuant to the regulations, a cost report hearing request must have been received by the Board within 180 days of the expiration of the 12 month period for issuance of the final contractor determination, or November 27, 2014. The Provider's appeal was received 1509 days later on July 18, 2018.

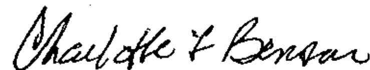
Therefore, the Board finds that the Provider's hearing request was not timely filed within 180 days of the expiration of the 12 month period for issuance of the final contractor determination and hereby dismisses this appeal.

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

Board Members Participating:

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

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DEPARTMENT OF HEALTH & HUMAN SERVICES

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16-1214 **CERTIFIED MAIL** AUG 01 2018

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RE: Jurisdictional Determination
Scottsdale Healthcare Hospitals--Osborn
Provider No.: 03-0038
FYEs: December 31, 2013
PRRB Case No.: 16-1214

Dear Mr. Ravindran and Mr. Bloom:

This case involves Scottsdale Healthcare Hospitals—Osborn's ("Scottsdale" or "Provider") appeal of its Medicare reimbursement for the fiscal year ending ("FYE") on December 31, 2013. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed Scottsdale's documentation in response to the Medicare Contractor's March 29, 2018 Jurisdictional Challenge. Following review of the documentation, the Board finds that it has jurisdiction to hear Scottsdale's Medicaid eligible days issue, but does not have jurisdiction to hear Scottsdale's appeal of its Supplemental Security Income ("SSI") percentage "provider-specific" issue, as this issue is already contained within a group appeal.[1] The Board's findings and jurisdictional determinations are explained below.

Pertinent Facts

On March 11, 2016, the Board received Scottsdale's request for a hearing ("RFH") regarding its Notice of Program Reimbursement ("NPR") for the cost reporting period ending on December 31, 2013. In its RFH, Scottsdale appeals a number of issues, including an SSI provider-specific issue, an SSI "systemic" issue and a Medicaid eligible days issue. Following Scottsdale's requests to transfer most of the issues to group appeals, the instant appeal was left with only two issues—SSI provider-specific and Medicaid eligible days.

[1] The Medicare Contractor's Jurisdictional Challenge questions the Board's jurisdiction to hear Scottsdale's SSI Provider specific issue, Medicaid eligible days issue, Medicaid fraction dual eligible days issue and outlier payments—fixed loss threshold issue. The latter two issues were transferred to group appeals, thus for efficiency sake, the Board will address the jurisdictional challenges to those issues within their respective group appeals.

In its Jurisdictional Challenge, the Medicare Contractor questions the Board's jurisdiction to consider both of the remaining issues. The Medicare Contractor claims that Scottsdale's SSI provider specific issue is the same as its SSI systemic issue that was transferred to a group appeal, PRRB Case No. 17-0011GC, thus Scottsdale impermissibly has the same issue in two appeals. The Medicare Contractor also argues that the Board should dismiss Scottsdale's Medicaid eligible days issue because Scottsdale did not properly claim or protest this issue as required under the Board jurisdiction regulations.

Scottsdale filed a April 13, 2018 Jurisdictional Response in which it argues that its SSI issues are "separate and distinct," and that its SSI systemic issue addresses the Center for Medicare & Medicaid Services' ("CMS") errors resulting from improper data matching process while its SSI provider-specific issue "address[es] the various errors of omission and commission that do not fit into the 'systemic errors' category."[2] In support of its Medicaid eligible days issue, Scottsdale argues that "the documentation necessary to pursue [Disproportionate Share Hospital ("DSH")] is often not available from the State in time to include all DSH/Medicaid Eligible Days . . . on the cost report[;]"[3] that DSH is not an item that must be adjusted or claimed on a cost report;[4] and that it "self-disallowed DSH in the cost report in accordance with Board Rule 7.2(B)."[5]

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 C.F.R. §§ 405.1835-405.1840 (2013), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more, and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2013), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (1) including a claim for the item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (2) for cost reporting periods ending on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Under Board Rule 4.5 (July 1, 2009), a provider may not appeal an issue from a final determination in more than one appeal.

SSI "provider-specific" issue

Scottsdale summarizes its provider-specific issue in the following manner:

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[2] Jurisdictional Response at 1-2.
[3] *Id.* at 6.
[4] *Id.* at 4.
[5] *Id.* at 6.

> The Provider contends that its[] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]. . . The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[6]

Scottsdale summarizes its SSI systemic issue in the following manner:

> The Provider[] . . . contend(s) that the SSI percentage[] calculated by [CMS] does not address all the deficiencies . . . and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Provider[] challenge[s] [its] SSI percentage[] based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days,
> 6. Failure to adhere to required notice and comment rulemaking procedures.[7]

In its SSI systemic issue statement, Scottsdale sets out a long list of reasons why it claims that CMS incorrectly computed its SSI percentage. In its SSI provider-specific issue statement, Scottsdale fails to describe any additional reasons or patient populations "entitled to SSI benefits" that would distinguish the two issues or differentiate the underlying data being challenged. The Board concludes, therefore, that Scottsdale's SSI provider-specific issue and its SSI systemic issue that was transferred to group appeal PRRB Case No. 17-0011GC, challenge the same underlying SSI data and are, ultimately, the same issue.

In addition, although Scottsdale's SSI provider-specific issue statement includes a proclamation that Scottsdale "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period[,]" the Board notes that Scottsdale's right to request realignment of its fiscal year for the SSI percentage calculation is a provider *election*, not an appealable issue before the Board.[8]

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[6] RFH TAB 3, at unnumbered page 1
[7] *Id.* at 1-2.
[8] 42 C.F.R. § 412.106(b)(3) (2008).

As such, because Scottsdale impermissibly has the same issue in two separate appeals,[9] the Board hereby dismisses Scottsdale's SSI provider-specific issue from the instant appeal; however, Scottsdale's appeal of the SSI data remains open within its SSI systemic issue in PRRB Case No. 17-0011GC.

Medicaid eligible days issue

In its RFH, Scottsdale claims that CMS "failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid percentage of the Medicare DSH calculation."[10] Scottsdale lists Audit Adjustment Numbers 5, 7, 22, 24, 27, 41 and "self-disallowed" as the adjustments pertinent to the issue.[11]

In its Jurisdictional Challenge, the Medicare Contractor points out that Scottsdale did not claim or protest the additional Medicaid days on its as-filed cost report, thus the Contractor argues that Scottsdale has not preserved its right to claim dissatisfaction with the number of Medicaid eligible days used for its DSH calculation.[12] In addition, in its Final Position Paper, the Medicare Contractor claims that Scottsdale has not provided any documentation "to show [that] it is entitled to additional days."[13] Although the Medicare Contractor goes on to state that if the Provider is able to supply certain information and the Board finds that it has jurisdiction over this issue, the Contractor believes that the "issue can be administratively resolved . . ."[14]

The Audit Adjustment Numbers cited by Scottsdale do not demonstrate an adjustment to the Provider's disputed Medicaid eligible days, and, according to Scottsdale's documentation, the cost report's $69,131 in protested amounts does not represent Scottsdale's Medicaid eligible days.[15] As such, Scottsdale does not appear to have claimed or protested the Medicaid eligible days it is appealing within its RFH, as claimed by the Medicare Contractor. However, for the fiscal year being reviewed, the Board's jurisdictional review must now also include an analysis based upon the steps set out in the newly published CMS Ruling "CMS-1727-R" ("CMS-1727-R" or "the Ruling")[16] CMS-1727-R sets out a five-step analysis for the Board to undertake in order to determine whether a provider is entitled to a PRRB hearing for an item that the provider appealed but did not include on its cost report.

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[9] See Board Rule 4.5.
[10] RFH TAB 3, at unnumbered page 4.
[11] *Id.*
[12] Jurisdictional Challenge at 4.
[13] Medicare Contractor's Final Position Paper at 12.
[14] *Id.* at 13.
[15] Jurisdictional Challenge Ex. I-5. Scottsdale's documentation specifically states that it is "protesting the inclusion of managed care days in the SSI% and identification of SSI days." *Id.* at 2.
[16] CMS Ruling CMS 1727-R states CMS' policy concerning its decision to follow the U.S. District Court for the District of Columbia's holding in *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d (D.D.C. 2016). CMS issued the Ruling on April 23, 2018.

The first step in the analysis involves the appeal's filing date and cost reporting period. A provider's appeal pending or filed on or after April 23, 2018, that concerns a cost reporting period ending on or after December 31, 2008, and beginning before January 1, 2016, is subject to CMS-1727-R.[17] Since the Board received Scottsdale's RFH concerning its FYE December 31, 2013 cost reporting period on March 11, 2016, the mandates set out in the Ruling apply to the 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."[18] Here, Scottsdale's appealed item is the number of Medicaid eligible patient days used by the Medicare Contractor to determine Scottsdale's Medicaid fraction and, ultimately, its DSH payment. DSH-eligible hospitals, such as Scottsdale, must submit Medicaid eligible days as part of the cost reporting process.[19] However, the Secretary's regulations that govern a hospital's cost reporting obligations state that a DSH-eligible hospital has the burden of furnishing data adequate to prove eligibility for each claimed Medicaid patient day and of verifying with the state that a patient was eligible for Medicaid during each claimed patient hospital day.[20] The Secretary, through the Medicare Contractors, may not make payment to a provider unless the provider has furnished the information requested by the Secretary,[21] thus, the Medicare Contractor may not include unverified Medicaid eligible patient days in a provider's Medicaid fraction calculation. In the instant appeal, Scottsdale claims that it was unable to verify, through no fault of its own, all of its Medicaid eligible patient days prior to its cost report filing deadline,[22] thus Scottsdale argues that its Medicaid fraction did not account for all of the Medicaid eligible days that it is entitled to have included in this calculation.

Accordingly, the Board finds that Scottsdale's Medicaid eligible patient days in the DSH calculation are 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.

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.[23] As Scottsdale's appeal was timely filed and Scottsdale 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.

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[17] CMS-1727-R at unnumbered page 5.
[18] *Id.* at unnumbered page 6.
[19] See *Danbury Hosp. v. Blue Cross and Blue Shield Ass'n*, PRRB Dec. No. 2014-D03 (Feb. 11, 2014), *declined review*, CMS Adm'r (Mar. 26, 2014); *Barberton Citizens Hospital v. Blue Cross and Blue Shield Ass'n*, PRRB Dec. No. 2015-D5 (Mar. 19, 2015).
[20] 42 C.F.R. § 412.106(b)(4)(iii) (2008).
[21] 42 U.S.C. § 1395g(a).
[22] Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. 42 C.F.R. § 413.24(f)(2) (2008).
[23] See 42 C.F.R. § 405.1835(a) (2008).

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, Scottsdale's Medicaid eligible days were not within the payment authority or discretion of the Medicare contractor because Scottsdale had not verified the days at the time that it filed its cost report, as explained above.

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.[24] 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, the Board finds that Scottsdale's appealed Medicaid eligible days issue is subject to a regulation that bound the Medicare Contractor such that it had no discretion or authority to make payment as sought by Scottsdale. Therefore, under the terms of CMS-1727-R, the Board "shall not apply the self-disallowance jurisdiction regulation" to Scottsdale's Medicaid eligible days issue when considering whether the issue meets the "dissatisfaction" jurisdictional requirement of 42 C.F.R. § 405.1835(a). Instead, the Board is to "apply all other applicable jurisdictional requirements . . . and process the appeal in accordance with its usual appeal procedures."[25]

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, Scottsdale did not self-disallow its Medicaid eligible days issue, thus this step is not applicable to this appeal.[26]

Since the Board's analysis under CMS-1727-R dictates that the Board shall not apply the self-disallowance jurisdiction regulation to Scottsdale's Medicaid eligible days issue, and because Scottsdale has met all other applicable jurisdictional requirements with respect to the instant appeal, the Board finds that it has jurisdiction over the specific Medicaid eligible days described in the "Conclusion" section below.

Conclusion

The Board finds as follows:

(1) Scottsdale's SSI "provider-specific" issue is the same as Scottsdale's SSI "systemic" issue set out in the group appeal for PRRB Case No. 17-0011GC. The Board, therefore, dismisses Scottsdale's duplicative SSI "provider-specific" issue from the instant appeal;[27] and

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[24] *Id.*
[25] CMS-1727-R at unnumbered page 7.
[26] *Id.*
[27] See Board Rule 4.5.

(2) The Board has jurisdiction to hear Scottsdale's Medicaid eligible days issue with respect to those Medicaid eligible days that were paid or verified by the relevant state after Scottsdale's cost report was submitted. The Board does not have jurisdiction to hear Scottsdale's Medicaid eligible days issue with respect to those Medicaid eligible days that were paid or verified by the relevant state prior to the submission of Scottsdale's cost report (an example of the latter are those Medicaid eligible days verified or paid by the relevant state prior to the submission of Scottsdale's cost report but merely unclaimed on that report). 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. It is the responsibility of both Scottsdale 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.

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 appeal.

Board Members Participating:
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A
Rob 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, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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AUG 0 2 2018

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President
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RE: Jurisdictional Decision

16-0972GC QRS Avera Health 2016 DSH Uncompensated Care Payments CIRP Group
16-1098GC QRS PAC FFY 2016 DSH Uncompensated Care CIRP Group
16-1100GC QRS Asante Health FFY 2016 DSH Uncompensated Care CIRP Group

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeals and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The various Providers in the above-referenced Common Issue Related Party ("CIRP") group appeals all filed their appeal requests from the Final Rule issued in the Federal Register on August 17, 2015: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates.

The Providers contend that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available to Disproportionate Share Hospital ("DSH") eligible hospitals therefore the preclusion of review provision found in the Social Security Act at § 1886(r)(3) does not apply.

Medicare Contractor's Contentions:

The Medicare Contractor filed jurisdictional challenges in these three group appeals arguing that the Board does not have jurisdiction over the group issue because 42 U.S.C. § 1395ww(r)(3) explicitly bars judicial and administrative review of the new DSH payment methodology. The Medicare Contractor cites to the decision in *Florida Health Sciences* in support of its argument, and concludes that the Board should dismiss these appeals.

Providers' Arguments:

The Providers respond that the Medicare Contractor is incorrect in its jurisdictional challenge for several reasons: first, the statute does not authorize the Secretary to estimate the uninsured patient population

percentage. Second, the PRRB may review the Secretary's estimates because the federal courts may also conduct such a review because the Providers are entitled to a writ of mandamus directing the Secretary to revise the estimates and the statute does not preclude challenges to the regulation and policies relied upon by the Secretary in the computation. Last, the Providers argue that a failure to permit mandamus relief will result in "serious" constitutional issues.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue in the above-referenced appeals because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[1]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[2] upheld the D.C. District Court's decision[3] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[4] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[5]

The Board finds that the same findings are applicable to the Providers' challenge to their 2016 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for 2016. The Board finds that in challenging the

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[1] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[2] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[2]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[3] 89 F. Supp. 3d 121 (D.D.C. 2015).
[4] 830 F.3d 515, 517.
[5] *Id.* at 519.

Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in the above referenced group appeals because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in each appeal, the Board hereby closes the above-referenced group appeals and removes them from its 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.

<u>Board Members</u>
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

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

RE: Jurisdictional Decision

15-1218GC QRS VHC FFY 2015 DSH Uncompensated Care Pool Calculation CIRP Group

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeals and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The various Providers in the above-referenced Common Issue Related Party ("CIRP") group appeals all filed their appeal requests from the Final Rule issued in the Federal Register on August 22, 2014: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2015 Rates.

The Providers contend that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available to Disproportionate Share Hospital ("DSH") eligible hospitals therefore the preclusion of review provision found in the Social Security Act at § 1886(r)(3) does not apply.

Medicare Contractor's Contentions:

The Medicare Contractor filed a jurisdictional challenge in this group appeal in which it argues that, although the Board has jurisdiction to determine if it has the authority to hear the Providers' appeal, 42 U.S.C. § 1395ww(r)(3) bars administrative review, therefore the Board is without the authority to decide the issue raised by the Providers in this appeal.

Providers' Arguments:

The Providers respond that the Medicare Contractor is incorrect in its jurisdictional challenge for several reasons: first, the statute does not authorize the Secretary to estimate the uninsured patient population percentage. Second, the PRRB may review the Secretary's estimates because the federal courts may also conduct such a review because the Providers are entitled to a writ of mandamus directing the Secretary to revise the estimates and the statute does not preclude challenges to the regulation and

policies relied upon by the Secretary in the computation. Last, the Providers argue that a failure to permit mandamus relief will result in "serious" constitutional issues.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue in case no. 15-1218GC because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[1]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[2] upheld the D.C. District Court's decision[3] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[4] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[5]

The Board finds that the same findings are applicable to the Providers' challenge to their 2015 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for 2015. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data

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[1] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

[2] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[2]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).

[3] 89 F. Supp. 3d 121 (D.D.C. 2015).

[4] 830 F.3d 515, 517.

[5] *Id.* at 519.

relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in case no. 15-1218GC because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes case no. 15-1218GC and removes the appeal from its 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
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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

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AUG 02 2018

CERTIFIED MAIL

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

RE: Jurisdictional Decision

15-1219GC	QRS MultiCare Health 2015 Uncompensated Care Pool Calculation CIRP
15-1220GC	QRS Novant Health 2015 Uncompensated Care Pool Calculation CIRP
15-1239GC	QRS Providence Health 2015 DSH Uncompensated Care Payment CIRP
15-1258GC	QRS BSWH 2015 DSH Uncompensated Care Payment CIRP
15-1259G	QRS 2015 DSH Uncompensated Care Payment Group
15-1261GC	QRS YNHHS 2015 DSH Uncompensated Care Payment CIRP
15-1262GC	QRS WFHC 2015 DSH Uncompensated Care Payment CIRP
15-1263GC	QRS Health First 2015 DSH Uncompensated Care Payment CIRP
15-1264GC	QRS Broward Health 2015 DSH Uncompensated Care Payment CIRP
15-1266GC	QRS Phoebe Putney Health 2015 DSH Uncompensated Care Payment CIRP
15-1404GC	QRS SGHS FFY 2015 DSH Uncompensated Care Payment CIRP Group

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeals and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The various Providers in the above-referenced Common Issue Related Party ("CIRP") and optional group appeals all filed their appeal requests from the Final Rule issued in the Federal Register on August 22, 2014: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2015 Rates.

The Providers contend that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available to Disproportionate Share Hospital ("DSH") eligible hospitals therefore the preclusion of review provision found in the Social Security Act at § 1886(r)(3) does not apply.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue in the above-referenced appeals because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42

C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[1]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[2] upheld the D.C. District Court's decision[3] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[4] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[5]

The Board finds that the same findings are applicable to the Providers' challenge to their 2015 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for 2015. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in the above referenced group appeals because judicial and administrative review of the calculation is barred

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[1] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[2] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[2]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[3] 89 F. Supp. 3d 121 (D.D.C. 2015).
[4] 830 F.3d 515, 517.
[5] *Id.* at 519.

by statute and regulation. As the Uncompensated Care DSH issue is the only issue in each appeal, the Board hereby closes the above-referenced group appeals and removes them from its 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.

<u>Board Members</u>
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

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AUG 02 2018

CERTIFIED MAIL

Healthcare Reimbursement Services, Inc.
Corinna Goron
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17101 Preston Road, Suite 220
Dallas, TX 75248-1372

RE: Jurisdictional Decision
HRS FFY 2016 UCC Distribution Pool Group
PRRB Case No. 16-0989G

Dear Ms. Goron,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts

The Providers all filed their appeal requests from the Final Rule issued in the Federal Register issued on August 27, 2015: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates.[1]

The Providers argue that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals.

Medicare Contractor's Arguments

The Medicare Contractor filed a jurisdiction challenge with the Board which argues that, although the Board has jurisdiction to determine if it has authority to hear the Providers' appeal, the statute at 42 U.S.C. § 1395ww(r)(3) bars administrative review, which means the Board is without authority to decide the issues raised by the Providers. The Medicare Contractor explains that the statute bars administrative or judicial review of any estimate of the Secretary for purposes of determining the factors described, which is what the Providers are contesting in this appeal. The Jurisdictional Challenge goes on to argue that each of the Providers' arguments cannot be reviewed under the statute and concludes that the Board does not have jurisdiction over the group issue.

[1] 80 Fed. Reg. 49325 (Aug. 17, 2015).

Providers' Arguments

The Providers respond that the Medicare Contractor is incorrect in its jurisdictional challenge for several reasons: first, the statute does not authorize the Secretary to estimate the uninsured patient population percentage. Second the PRRB may review the Secretary's estimates because the federal courts may also conduct such a review because the Providers are entitled to a writ of mandamus directing the Secretary to revise the estimates and the statute does not preclude challenges to the regulation and policies relied upon by the Secretary in the computation. Last, the Providers argue that a failure to permit mandamus relief will result in "serious" constitutional issues.

Board's Decision

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue in case no. 16-0989G because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[2]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[3] upheld the D.C. District Court's decision[4] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[5] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[6]

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[2] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[3] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[3]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[4] 89 F. Supp. 3d 121 (D.D.C. 2015).
[5] 830 F.3d 515, 517.
[6] *Id.* at 519.

The Board finds that the same findings are applicable to the Providers' challenge to their 2016 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for 2016. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in the case no. 16-0989G because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes the case no. 16-0989G and removes the appeal from its 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
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

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AUG 02 2018

CERTIFIED MAIL

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

RE: Jurisdictional Decision

QRS BSWH FFY 2016 DSH Uncompensated Care Payments CIRP Group, 16-1097GC
QRS Health First FFY 2016 DSH Uncompensated Care Payments CIRP Group, 16-1095GC
QRS Providence Health & Services 2016 DSH Uncompensated Care Payments CIRP Group, 16-0975GC
QRS Novant Health 2016 DSH Uncompensated Care Payments CIRP Group, 16-0971GC
QRS BLMTN FFY 2016 DSH Uncompensated Care Payments CIRP Group, 16-1104GC
QRS WFHC FFY 2016 DSH Uncompensated Care Payments CIRP Group, 16-1106GC
QRS YNHHS FFY 2016 DSH Uncompensated Care Payments CIRP Group, 16-1107GC
QRS SSEPR FFY 2016 DSH Uncompensated Care Payments CIRP Group, 16-1108GC
QRS Carolinas Health 2016 Uncompensated Care Payments CIRP Group, 16-1019GC
QRS FFY 2016 DSH Uncompensated Care Payments Group, 16-1109GC

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeals and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The various Providers in the above-referenced Common Issue Related Party ("CIRP") group appeals all filed their appeal requests from the Final Rule issued in the Federal Register on August 17, 2015: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates.

The Providers contend that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available to Disproportionate Share Hospital ("DSH") eligible hospitals therefore the preclusion of review provision found in the Social Security Act at § 1886(r)(3) does not apply.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue in the above-referenced appeals because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[1]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[2] upheld the D.C. District Court's decision[3] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[4] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[5]

The Board finds that the same findings are applicable to the Providers' challenge to their 2016 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for 2016. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in the above referenced group appeals because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in each appeal, the Board hereby closes the above-referenced group appeals and removes them from its docket.

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[1] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[2] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[2]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[3] 89 F. Supp. 3d 121 (D.D.C. 2015).
[4] 830 F.3d 515, 517.
[5] *Id.* at 519.

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
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FOR THE BOARD

Board Member

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

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AUG 02 2018

CERTIFIED MAIL

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RE: Jurisdictional Decision
HRS FFY 2015 UCC Distribution Pool Group
PRRB Case No. 15-1257G

Dear Ms. Goron,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts

The Providers all filed their appeal requests from the Final Rule issued in the Federal Register issued on August 22, 2014: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2015 Rates.[1]

The Providers argue that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals.

Medicare Contractor's Arguments

The Medicare Contractor argues that the Board should dismiss this appeal because Board review of the issue under dispute is barred by 42 U.S.C. § 1395ww(r)(3), therefore the Board does not have jurisdiction over the issue. The Medicare Contractor cites to the decision in *Florida Health Sciences* in support of its argument, and concludes that the Board should dismiss this appeal.

Providers' Arguments

The Providers respond that the Medicare Contractor is incorrect in its jurisdictional challenge for several reasons: first, the statute does not authorize the Secretary to estimate the uninsured patient population percentage. Second the PRRB may review the Secretary's estimates because the federal courts may also conduct such a review because the Providers are entitled to a writ of mandamus directing the Secretary to revise the estimates and the statute does not preclude challenges to the regulation and policies relied

[1] 79 Fed. Reg. 49845 (Aug. 22, 2014).

upon by the Secretary in the computation. Last, the Providers argue that a failure to permit mandamus relief will result in "serious" constitutional issues.

Board's Decision

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue in case no. 15-1257G because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[2]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[3] upheld the D.C. District Court's decision[4] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[5] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[6]

The Board finds that the same findings are applicable to the Providers' challenge to their 2015 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for FY 2015. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data

---

[2] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[3] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[3]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[4] 89 F. Supp. 3d 121 (D.D.C. 2015).
[5] 830 F.3d 515, 517.
[6] *Id.* at 519.

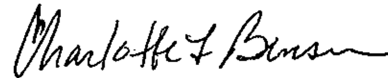
relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in the case no. 15-1257G because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes the case no. 15-1257G and removes the appeal from its 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
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 C. Leong Esq., FSS
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

AUG 02 2018

CERTIFIED MAIL

Horty, Springer & Mattern
Daniel Mulholland, III
4614 Fifth Avenue
Pittsburgh, PA 15213

RE: Jurisdictional Decision
North Oaks Medical Center
Provider No. 19-0015
FYE 6/30/2016
Case No. 16-1330

Dear Mr. Mulholland,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

North Oaks Medical Center, the Provider, filed its appeal request with the Board on March 29, 2016. In its request the Provider referenced two final determinations: 80 Fed. Reg. 60055 (Oct. 5, 2015), which corrected technical and typographical errors in the Final Rule issued on August 17, 2015 for the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates. The Provider also referenced the publications of the Disproportionate Share Hospital ("DSH") calculation on CMS' website.

The Provider argues that the Secretary's determination under appeal was based on a calculation error related to the third factor used to calculate the additional payment for the Provider's proportion of uncompensated care under 42 C.F.R. § 412.106(g)(iii).

Medicare Contractor's Contentions:

The Medicare Contractor filed a jurisdictional challenge with the Board on May 16, 2018. It argues that, although the Board has jurisdiction to determine if it has the authority to hear the Providers' appeal, 42 U.S.C. § 1395ww(r)(3) bars administrative review, therefore the Board is without the authority to decide the issue raised by the Providers in this appeal.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue in case no. 16-1330 because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R.

§ 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[1]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[2] upheld the D.C. District Court's decision[3] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[4] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[5]

The Board finds that the same findings are applicable to the Provider's challenge to its FY 2016 uncompensated care payments. As in *Tampa General*, the Provider here is challenging the calculation of the amount it received for uncompensated care for 2016. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Provider is seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Provider is challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in case no. 16-1330 because judicial and administrative review of the calculation is barred by statute and

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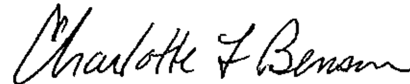
[1] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[2] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[2]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[3] 89 F. Supp. 3d 121 (D.D.C. 2015).
[4] 830 F.3d 515, 517.
[5] *Id.* at 519.

regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes case no. 16-1330 and removes the appeal from its 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.

<u>Board Members</u>
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 C. Leong Esq., FSS
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Mounir Kamal
Director, JH Provider Audit & Reimbursement
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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AUG 0 3 2018

CERTIFIED MAIL

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

RE: Jurisdictional Decision
See Attached Listing of Appeals

Dear Ms. Webster,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the appeals referenced in the attached listing and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The Providers all filed their appeal requests from the Final Rule issued in the Federal Register issued on August 22, 2016: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2017 Rates.[1]

The Providers are challenging the procedural and substantive validity of the Secretary's determination of their disproportionate share hospital ("DSH") payment amounts for uncompensated care costs for Federal Fiscal Year 2017. The Providers contend that the Secretary's determinations and rule are arbitrary, capricious, reflect an abuse of discretion, are not based upon substantial evidence, violate the notice and comment rulemaking requirements and are otherwise contrary to law.

The Medicare Contractor has not filed a jurisdictional challenge in any of these appeals.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[2]

[1] 81 Fed. Reg. 56762 (Aug. 22, 2018).

[2] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the

(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[3] upheld the D.C. District Court's decision[4] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[5] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[6]

The Board finds that the same findings are applicable to the Providers' challenge to their 2017 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for FYs 2017. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in the group appeals referenced in the attached listing because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in each appeal, the Board hereby closes the referenced group appeals and removes them from its 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.

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estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

[3] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[3]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).

[4] 89 F. Supp. 3d 121 (D.D.C. 2015).

[5] 830 F.3d 515, 517.

[6] *Id.* at 519.

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
Listing of Appeals

cc:

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Akin Gump 2017 DSH Uncompensated Care Payment Groups

Case No.	Group Name	MAC
17-0893G	Akin Gump 2017 DSH Uncompensated Care Payment Group	National Government Services, Inc.
17-0894GC	Akin Gump Trinity Health 2017 DSH Uncompensated Care Payment CIRP Group	National Government Services, Inc.
17-0895GC	Rochester Regional Health System 2017 DSH Uncompensated Care Payment CIRP Group	National Government Services, Inc.
17-0897GC	United Health Services 2017 DSH Uncompensated Care Payment CIRP Group	National Government Services, Inc.
17-0900GC	UMass Memorial Health Care 2017 DSH Uncompensated Care Payment CIRP Group	National Government Services, Inc.
17-0901GC	UPMC 2017 DSH Uncompensated Care Payment CIRP Group	Novitas Solutions, Inc.
17-0923GC	Akin Gump Saint Francis Health System 2017 DSH Uncompensated Care Payment CIRP Group	Novitas Solutions, Inc.
17-0924GC	Akin Gump University of Rochester Medical Center 2017 DSH Uncompensated Care Payment	National Government Services, Inc.
17-0925GC	Akin Gump Sanford Health 2017 DSH Uncompensated Care Payment CIRP Group	Noridian Healthcare Solutions, LLC
17-0936GC	Akin Gump St. Elizabeth Healthcare 2017 DSH Uncompensated Care Payment CIRP Group	CGS Administrators
17-0937GC	Akin Gump Wake Forest Baptist Health 2017 DSH Uncompensated Care Payment CIRP Group	Palmetto, C/O NGS
17-0938GC	Akin Gump Steward Health 2017 DSH Uncompensated Care Payment CIRP Group	National Government Services, Inc.
17-0939GC	Akin Gump Verity Health System 2017 DSH Uncompensated Care Payment CIRP Group	Noridian Healthcare Solutions
17-0965GC	Akin Gump North Shore LIJ 2017 DSH Uncompensated Care Payment CIRP Group	National Government Services, Inc.
17-0966GC	Akin Gump Orlando Health 2017 DSH Uncompensated Care Payment CIRP Group	First Coast Service Options, Inc.
17-0967GC	Akin Gump Premier Health 2017 DSH Uncompensated Care Payment CIRP Group	CGS Administrators
17-0968GC	Akin Gump Catholic Health Initiatives 2017 DSH Uncompensated Care Payment CIRP Group	Novitas Solutions, Inc.
17-0969GC	Akin Gump Baptist Health South Florida 2017 DSH Uncompensated Care Payment CIRP Group	First Coast Service Options, Inc.
17-0970GC	Akin Gump RWJ Barnabas Health 2017 DSH Uncompensated Care Payment CIRP Group	Novitas Solutions, Inc.
17-0971GC	Akin Gump Allina Health 2017 DSH Uncompensated Care Payment CIRP Group	National Government Services
17-0975GC	Akin Gump IASIS Healthcare 2017 DSH Uncompensated Care Payment CIRP Group	Noridian Healthcare Solutions, LLC
17-0976GC	Akin Gump Greenville Health System 2017 DSH Uncompensated Care Payment CIRP Group	Palmetto, C/O NGS
17-0982GC	Akin Gump Geisinger Health System 2017 DSH Uncompensated Care Payment CIRP Group	Novitas Solutions, Inc.
17-0983GC	Akin Gump Einstein Health 2017 DSH Uncompensated Care Payment CIRP Group	Novitas Solutions, Inc.
17-0985GC	Akin Gump Duke University Health System 2017 DSH Uncompensated Care Payment CIRP Grc	Palmetto, C/O NGS
17-0989GC	Akin Gump Covenant Health 2017 DSH Uncompensated Care Payment CIRP Group	Palmetto GBA
17-0990GC	Akin Gump INTEGRIS Health 2017 DSH Uncompensated Care Payment CIRP Group	Novitas Solutions, Inc.
17-0996GC	Akin Gump Mount Sinai Health System 2017 DSH Uncompensated Care Payment CIRP Group	National Government Services, Inc.
17-0997GC	Akin Gump Montefiore Health System 2017 DSH Uncompensated Care Payment CIRP Group	National Government Services, Inc.
17-0998GC	Akin Gump Legacy Health 2017 DSH Uncompensated Care Payment CIRP Group	Noridian Healthcare Solutions, LLC
17-0999GC	Akin Gump Memorial Hermann 2017 DSH Uncompensated Care Payment CIRP Group	Novitas Solutions, Inc.
17-1002GC	Akin Gump Methodist Health System 2017 DSH Uncompensated Care Payment CIRP Group	Novitas Solutions, Inc.

17-1003GC Akin Gump Methodist Hospital System 2017 DSH Uncompensated Care Payment CIRP Group Novitas Solutions, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 14-0857GC

AUG 03 2018

CERTIFIED MAIL

Healthcare Reimbursement Services, Inc.
Corinna Goron
President
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Dallas, TX 75248

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

RE: HRS FMOLHS 2010 DSH SSI Percentage CIRP Group, FYE 2010
PRRB Case No.: 14-0857GC

Dear Ms. Goron and Mr. Kamal:

The Provider Reimbursement Review Board ("Board") has reviewed the Clarification of Issue and EJR Request ("Clarification Letter") dated July 31, 2018 for the above-referenced group. The decision of the Board is set forth below.

Background

On November 18, 2013, the Board received the request to establish a Common Issue Related Party ("CIRP") group appeal for the "HRS 2010 FMOLHS DSH/SSI Percentage CIRP Group". The Board established case number 14-0857GC. At the same time, the Board received two other group appeal requests for FMOLHS 2010 and established four separate group appeals, each group appeal limited one distinct legal issue as required by regulation:

14-0870GC HRS FMOLHS 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days,
14-0868GC HRS FMOLHS 2010 DSH SSI Fraction Medicare Managed Care Part C Days,
14-0864GC HRS FMOLHS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP, and
14-0860GC HRS FMOLHS 2010 SSI Fraction Dual Eligible Days CIRP.

On May 4, 2018 the Medicare Contractor filed a jurisdictional challenge with the Board to which the Providers responded on June 6, 2018.

On July 5, 2018 the Board issued its jurisdictional decision. As the Board explained, because the original group appeal involved several distinct legal issues, in violation of 42 C.F.R. § 405.1837(a)(2) and PRRB Rule 13, several distinct issues had been removed from this group appeal and those issues were currently pending in other group appeals. The Board found that the

issue in this group appeal is limited to the SSI Systemic Errors Issue as it related to utilizing the best available data when matching the MEDPAR to the information provided by SSA and dismissed several other distinct issues that it found resided in other group appeals involving the same providers for the same fiscal years.

By letter dated July 18, 2018, the Providers requested Expedited Judicial Review ("EJR") for 3 issues: (1) the treatment of Part C days as days entitled to benefits under Part A for purposes of the DSH calculation, *see* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004); 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007); (2) the treatment of other days for which the beneficiary did not receive Part A payments, such as days for which the beneficiary's Part A benefits were exhausted and days for which Medicare Part A was a secondary payor, as days entitled to benefits under Part A for purposes of the DSH calculation, *see id.*; and, (3) the treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation, *see* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010).

On July 27, 2018, the Board denied the Providers' EJR requests after review of the requests and the other cases currently before the Board involving the same providers and the same cost reports. The Board reminded the Providers of its jurisdictional decision that the sole issue in this group appeal is limited to the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MEDPAR to the information provided by SSA.

By July 30, 2018 letter, the Providers requested a postponement of the hearing in this matter scheduled for August 6, 2018. The basis for this request was to allow the Providers to move this group appeal (with three other group cases scheduled for hearing the same date) to federal court. The Board denied the requested postponement on July 30, 2018.

Finally, on July 31, 2018, the Providers submitted the Clarification letter, which is the subject of this Board decision. In the Clarification Letter, the Providers state:

> The Providers are not contending that the SSI tape sent by SSA to CMS contained individuals that failed to match with CMS's MedPAR file due to a flaw in the matching methodology or due to the use of a specific update of the MedPAR file, or for any of the other alleged errors in methodology that were argued in *Baystate.*[1]

The Clarification Letter continues on to state that:

> The providers have fully explained the issue they planned to pursue with group 14-0857GC in their Final Position Paper. The Final Position Paper explains how the Providers are primarily seeking a consistent definition of the term "entitled", and a consistent application of that definition in both the numerator and denominator of the SSI fraction.

[1] Healthcare Reimbursement Services, Inc. July 31, 2018 letter, p. 1.

. . . .

> . . . the Providers seek a return to the previous regulatory interpretation of the term "entitled" whereby paid SSI days are compared to paid Medicare Part A days.[2]

Board's Decision

The Board finds that the issue presented by the Providers in the Clarification Letter is, *as identified by the Providers,* currently pending in another group appeal. Specifically, the Statement of Legal Basis filed by the Providers in Case No. 14-0860GC, states:

> . . . The Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.[3]

Given that this issue is currently pending in another group appeal (14-0860GC), the Providers are in violation of PRRB Rule 4.5, which states, "A Provider may not appeal an issue from a final determination in more than one appeal."

Furthermore, 42 C.F.R. § 405.1868(a) provides that:

> The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of Section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.

Based on PRRB Rule 4.5 and 42 C.F.R. § 405.1868(a), the Board finds that the issue offered by the Providers in the Clarification Letter is not, and cannot be, the issue pending in 14-0857GC.

As the Board ruled in its July 5, 2018 jurisdictional decision and its July 27, 2018 denial of the Providers' EJR requests, the issue in this group appeal is limited to the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MEDPAR to the information provided by SSA.

The Board finds that the Providers have withdrawn the sole issue in this appeal based on the

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[2] *Id.* at p. 2.

[3] Providers' Statement of the Legal Basis, Case No. 14-0860GC. [Emphasis in original].

following statement in the Providers' Clarification letter:

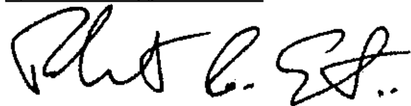
> The Providers are not contending that the SSI tape sent by SSA to CMS contained individuals that failed to match with CMS's MedPAR file due to a flaw in the matching methodology or due to the use of a specific update of the MedPAR file, or for any of the other alleged errors in methodology that were argued in *Baystate.*[4]

Accordingly, the current case, PRRB Case No. 14-0857GC is hereby dismissed.

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 appeal.

Board Members:
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), 42 C.F.R. §§ 405.1868(a), 405.1875 and 405.1877.
cc: Wilson Leong, FSS

[4] Healthcare Reimbursement Services, Inc. July 31, 2018 letter, p. 1.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 13-3120GC

AUG 03 2018

CERTIFIED MAIL

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

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

RE: HRS FMOLHS 2009 DSH SSI Percentage Baystate Errors CIRP Group, FYE 2009
Case No. 13-3120GC

Dear Ms. Goron and Mr. Kamal:

The Provider Reimbursement Review Board ("Board") has reviewed the Clarification of Issue and EJR Request ("Clarification Letter") dated July 31, 2018 for the above-referenced group. The decision of the Board is set forth below.

Background

On August 23, 2013, the Board received the request to establish a Common Issue Related Party ("CIRP") group appeal for the "HRS 2009 FMOLHS SSI Percentage CIRP Group" and the Board established the current case# 13-3120G. On August 26th, 2013 the following appeals were also filed with the Board:

1. 13-3303GC HRS FMOLHS 2009 DSH Medicare Managed Care Part C Days; and,
2. 13-3304GC HRS FMOLHS 2009 DSH Payment Dual Eligible Days.

On April 26, 2018 the Medicare Contractor filed a jurisdictional challenge with the Board to which the Providers responded on June 6, 2018.

On July 5, 2018 the Board issued its jurisdictional decision. As the Board explained, because the original group appeal involved several distinct legal issues, in violation of 42 C.F.R. § 405.1837(a)(2) and PRRB Rule 13, several distinct issues had been removed from this group appeal and those issues were currently pending in other group appeals. The Board found that the issue in this group appeal is limited to the SSI Systemic Errors Issue as it related to utilizing the best available data when matching the MEDPAR to the information provided by SSA and

dismissed several other distinct issues that it found resided in other group appeals involving the same providers for the same fiscal years.

By letter dated July 18, 2018, the Providers requested Expedited Judicial Review ("EJR") for 3 issues: (1) the treatment of Part C days as days entitled to benefits under Part A for purposes of the DSH calculation, *see* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004); 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007); (2) the treatment of other days for which the beneficiary did not receive Part A payments, such as days for which the beneficiary's Part A benefits were exhausted and days for which Medicare Part A was a secondary payor, as days entitled to benefits under Part A for purposes of the DSH calculation, *see id.*; and, (3) the treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation, *see* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010).

On July 27, 2018, the Board denied the Providers' EJR requests after review of the requests and the other cases currently before the Board involving the same providers and the same cost reports. The Board reminded the Providers of its jurisdictional decision that the sole issue in this group appeal is limited to the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MEDPAR to the information provided by SSA.

By July 30, 2018 letter, the Providers requested a postponement of the hearing in this matter scheduled for August 6, 2018. The basis for this request was to allow the Providers to move this group appeal (with three other group cases scheduled for hearing the same date) to federal court. The Board denied the requested postponement on July 30, 2018.

Finally, on July 31, 2018, the Providers submitted the Clarification letter, which is the subject of this Board decision. In the Clarification Letter, the Providers state:

> The Providers are not contending that the SSI tape sent by SSA to CMS contained individuals that failed to match with CMS's MedPAR file due to a flaw in the matching methodology or due to the use of a specific update of the MedPAR file, or for any of the other alleged errors in methodology that were argued in *Baystate.*[1]

The Clarification Letter continues on to state that:

> The providers have fully explained the issue they planned to pursue with group 14-0857GC in their Final Position Paper. The Final Position Paper explains how the Providers are primarily seeking a consistent definition of the term "entitled", and a consistent application of that definition in both the numerator and denominator of the SSI fraction.
>
> . . . .

[1] Healthcare Reimbursement Services, Inc. July 31, 2018 letter, p. 1.

> . . . the Providers seek a return to the previous regulatory interpretation of the term "entitled" whereby paid SSI days are compared to paid Medicare Part A days.[2]

Board's Decision

The Board finds that the issue presented by the Providers in the Clarification Letter is, *as identified by the Providers,* currently pending in another group appeal. Specifically, the Statement of Legal Basis filed by the Providers in Case No. 13-3304GC, states:

> . . . The Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.[3]

Given that this issue is currently pending in another group appeal (13-3304GC), the Providers are in violation of PRRB Rule 4.5, which states, "A Provider may not appeal an issue from a final determination in more than one appeal."

Furthermore, 42 C.F.R. § 405.1868(a) provides that:

> The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of Section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.

Based on PRRB Rule 4.5 and 42 C.F.R. § 405.1868(a), the Board finds that the issue offered by the Providers in the Clarification Letter is not, and cannot be, the issue pending in Case No. 13-3120GC.

As the Board ruled in its July 5, 2018 jurisdictional decision and its July 27, 2018 denial of the Providers' EJR requests, the issue in this group appeal is limited to the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MEDPAR to the information provided by SSA.

The Board finds that the Providers have withdrawn the sole issue in this appeal based on the following statement in the Providers' Clarification letter:

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[2] *Id.* at p. 2.

[3] Providers' Statement of the Legal Basis, Case No. 14-0860GC. [Emphasis in original].

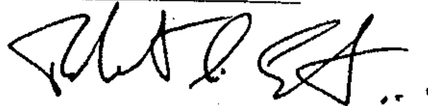
> The Providers are not contending that the SSI tape sent by SSA to CMS contained individuals that failed to match with CMS's MedPAR file due to a flaw in the matching methodology or due to the use of a specific update of the MedPAR file, or for any of the other alleged errors in methodology that were argued in *Baystate.*[4]

Accordingly, the current case, PRRB Case No. 13-3113GC is hereby dismissed.

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:
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), 42 C.F.R. §§ 405.1868(a), 405.1875 and 405.1877.
cc: Wilson Leong, FSS

[4] Healthcare Reimbursement Services, Inc. July 31, 2018 letter, p. 1.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Refer to: 13-3113GC

AUG 03 2018

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

RE: HRS FMOLHS 2007 DSH SSI Percentage Baystate Errors CIRP Group FYE 2007
PRRB Case No.: 13-3113GC

Dear Ms. Goron and Mr. Kamal:

The Provider Reimbursement Review Board ("Board") has reviewed the Clarification of Issue and EJR Request ("Clarification Letter") dated July 31, 2018 for the above-referenced group. The decision of the Board is set forth below.

Background

On November 18, 2013, the Board received the request to establish a Common Issue Related Party ("CIRP") group appeal for the SSI *Baystate* errors issue for Franciscan Missionaries of Our Lady Health System ("FMOLHS") providers' 2007 fiscal year ends ("FYE") and established the current case # 13-3113GC. The Board also established the following group appeals, each group appeal limited one distinct legal issue as required by regulation and PRRB Rule:

1. 13-3443GC HRS FMOLHS 2007 DSH Payment Dual Eligible Days CIRP Group;
2. 15-0800GC HRS FMOLHS 2007 SSI Fraction Dual Eligible Days CIRP Group;
3. 15-0799 HRS FMOLHS 2007 SSI Fraction Medicare Managed Care Part C Days CIRP Group; and,
4. 13-3344GC HRS FMOLHS 2007 DSH Medicare Managed Care Part C Days CIRP Group.

On April 3, 2018 the Medicare Contractor filed a jurisdictional challenge with the Board to which the Providers responded on May 24, 2018.

On July 5, 2018 the Board issued its jurisdictional decision. As the Board explained, because the original group appeal involved several distinct legal issues, in violation of 42 C.F.R. §

405.1837(a)(2) and PRRB Rule 13, several distinct issues had been removed from this group appeal and those issues were currently pending in other group appeals. The Board found that the issue in this group appeal is limited to the SSI Systemic Errors Issue as it related to utilizing the best available data when matching the MEDPAR to the information provided by SSA and dismissed several other distinct issues that it found resided in other group appeals involving the same providers for the same fiscal years.

By letter dated July 18, 2018, the Providers requested Expedited Judicial Review ("EJR") for 3 issues: (1) the treatment of Part C days as days entitled to benefits under Part A for purposes of the DSH calculation, *see* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004); 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007); (2) the treatment of other days for which the beneficiary did not receive Part A payments, such as days for which the beneficiary's Part A benefits were exhausted and days for which Medicare Part A was a secondary payor, as days entitled to benefits under Part A for purposes of the DSH calculation, *see id.*; and, (3) the treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation, *see* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010).

On July 27, 2018, the Board denied the Providers' EJR requests after review of the requests and the other cases currently before the Board involving the same providers and the same cost reports. The Board reminded the Providers of its jurisdictional decision that the sole issue in this group appeal is limited to the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MEDPAR to the information provided by SSA

By July 30, 2018 letter, the Providers requested a postponement of the hearing in this matter scheduled for August 6, 2018. The basis for this request was to allow the Providers to move this group appeal (with three other group cases scheduled for hearing the same date) to federal court. The Board denied the requested postponement on July 30, 2018.

Finally, on July 31, 2018, the Providers submitted the Clarification letter, which is the subject of this Board decision. In the Clarification Letter, the Providers state:

> The Providers are not contending that the SSI tape sent by SSA to CMS contained individuals that failed to match with CMS's MedPAR file due to a flaw in the matching methodology or due to the use of a specific update of the MedPAR file, or for any of the other alleged errors in methodology that were argued in *Baystate.*[1]

The Clarification Letter continues on to state that:

> The providers have fully explained the issue they planned to pursue with group 14-0857GC in their Final Position Paper. The Final Position Paper explains how the Providers are primarily seeking a consistent definition of the term "entitled", and a consistent application of that definition in both the numerator and

[1] Healthcare Reimbursement Services, Inc. July 31, 2018 letter, p. 1.

> denominator of the SSI fraction.
>
> . . . .
>
> . . . the Providers seek a return to the previous regulatory interpretation of the term "entitled" whereby paid SSI days are compared to paid Medicare Part A days.[2]

Board's Decision

The Board finds that the issue presented by the Providers in the Clarification Letter is, *as identified by the Providers,* currently pending in another group appeal. Specifically, the Statement of Legal Basis filed by the Providers in Case No. 13-3443GC, states:

> . . . The Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.[3]

Given that this issue is currently pending in another group appeal (13-3443GC), the Providers are in violation of PRRB Rule 4.5, which states, "A Provider may not appeal an issue from a final determination in more than one appeal."

Furthermore, 42 C.F.R. § 405.1868(a) provides that:

> The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of Section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.

Based on PRRB Rule 4.5 and 42 C.F.R. § 405.1868(a), the Board finds that the issue offered by the Providers in the Clarification Letter is not, and cannot be, the issue pending in Case No. 13-3113GC.

As the Board ruled in its July 5, 2018 jurisdictional decision and its July 27, 2018 denial of the Providers' EJR requests, the issue in this group appeal is limited to the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MEDPAR to the information

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[2] *Id.* at p. 2.

[3] Providers' Statement of the Legal Basis, Case No. 14-0860GC. [Emphasis in original].

provided by SSA.

The Board finds that the Providers have withdrawn the sole issue in this appeal based on the following statement in the Providers' Clarification letter:

> The Providers are not contending that the SSI tape sent by SSA to CMS contained individuals that failed to match with CMS's MedPAR file due to a flaw in the matching methodology or due to the use of a specific update of the MedPAR file, or for any of the other alleged errors in methodology that were argued in *Baystate.*[4]

Accordingly, the current case, PRRB Case No. 13-3113GC is hereby dismissed.

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:
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), 42 C.F.R. §§ 405.1868(a), 405.1875 and 405.1877.
cc: Wilson Leong, FSS

[4] Healthcare Reimbursement Services, Inc. July 31, 2018 letter, p. 1.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Refer to: 13-3117GC

AUG 03 2018

CERTIFIED MAIL

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

RE: HRS FMOLHS 2008 DSH SSI Percentage CIRP Group, FYE 2008
PRRB Case No.: 13-3117GC

Dear Ms. Goron and Mr. Kamal:

The Provider Reimbursement Review Board ("Board") has reviewed the Clarification of Issue and EJR Request ("Clarification Letter") dated July 31, 2018 for the above-referenced group. The decision of the Board is set forth below.

Background

On August 23, 2013, the Board received the request to establish a Common Issue Related Party ("CIRP") group appeal for the SSI *Baystate* errors issue for Franciscan Missionaries of Our Lady Health System ("FMOLHS") providers' 2008 fiscal year ends ("FYE") and established the current case # 13-3117GC. The Board also established the following group appeals, each group appeal limited one distinct legal issue as required by regulation and PRRB Rule:

1. 13-3100GC HRS FMOLHS 2008 DSH Medicare Managed Care Part C Days CIRP Group; and,
2. 13-3115GC HRS FMOLHS 2008 DSH Dual Eligible Days CIRP Group.

On April 23, 2018 the Medicare Contractor filed a jurisdictional challenge with the Board to which the Providers responded on May 24, 2018.

On July 5, 2018 the Board issued its jurisdictional decision. As thc Board explained, because the original group appeal involved several distinct legal issues, in violation of 42 C.F.R. § 405.1837(a)(2) and PRRB Rule 13, several distinct issues had been removed from this group appeal and those issues were currently pending in other group appeals. The Board found that the issue in this group appeal is limited to the SSI Systemic Errors Issue as it related to utilizing the

best available data when matching the MEDPAR to the information provided by SSA and dismissed several other distinct issues that it found resided in other group appeals involving the same providers for the same fiscal years.

By letter dated July 18, 2018, the Providers requested Expedited Judicial Review ("EJR") for 3 issues: (1) the treatment of Part C days as days entitled to benefits under Part A for purposes of the DSH calculation, *see* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004); 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007); (2) the treatment of other days for which the beneficiary did not receive Part A payments, such as days for which the beneficiary's Part A benefits were exhausted and days for which Medicare Part A was a secondary payor, as days entitled to benefits under Part A for purposes of the DSH calculation, *see id.*; and, (3) the treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation, *see* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010).

On July 27, 2018, the Board denied the Providers' EJR requests after review of the requests and the other cases currently before the Board involving the same providers and the same cost reports. The Board reminded the Providers of its jurisdictional decision that the sole issue in this group appeal is limited to the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MEDPAR to the information provided by SSA.

By July 30, 2018 letter, the Providers requested a postponement of the hearing in this matter scheduled for August 6, 2018. The basis for this request was to allow the Providers to move this group appeal (with three other group cases scheduled for hearing the same date) to federal court. The Board denied the requested postponement on July 30, 2018.

Finally, on July 31, 2018, the Providers submitted the Clarification letter, which is the subject of this Board decision. In the Clarification Letter, the Providers state:

> The Providers are not contending that the SSI tape sent by SSA to CMS contained individuals that failed to match with CMS's MedPAR file due to a flaw in the matching methodology or due to the use of a specific update of the MedPAR file, or for any of the other alleged errors in methodology that were argued in *Baystate.*[1]

The Clarification Letter continues on to state that:

> The providers have fully explained the issue they planned to pursue with group 14-0857GC in their Final Position Paper. The Final Position Paper explains how the Providers are primarily seeking a consistent definition of the term "entitled", and a consistent application of that definition in both the numerator and denominator of the SSI fraction.

[1] Healthcare Reimbursement Services, Inc. July 31, 2018 letter, p. 1.

. . . .

> . . . the Providers seek a return to the previous regulatory interpretation of the term "entitled" whereby paid SSI days are compared to paid Medicare Part A days.[2]

Board's Decision

The Board finds that the issue presented by the Providers in the Clarification Letter is, *as identified by the Providers,* currently pending in another group appeal. Specifically, the Statement of Legal Basis filed by the Providers in Case No. 13-3115GC, states:

> . . . The Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.[3]

Given that this issue is currently pending in another group appeal (13-3115GC), the Providers are in violation of PRRB Rule 4.5, which states, "A Provider may not appeal an issue from a final determination in more than one appeal."

Furthermore, 42 C.F.R. § 405.1868(a) provides that:

> The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of Section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.

Based on PRRB Rule 4.5 and 42 C.F.R. § 405.1868(a), the Board finds that the issue offered by the Providers in the Clarification Letter is not, and cannot be, the issue pending in Case No. 13-3117GC.

As the Board ruled in its July 5, 2018 jurisdictional decision and its July 27, 2018 denial of the Providers' EJR requests, the issue in this group appeal is limited to the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MEDPAR to the information provided by SSA.

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[2] *Id.* at p. 2.

[3] Providers' Statement of the Legal Basis, Case No. 14-0860GC. [Emphasis in original].

The Board finds that the Providers have withdrawn the sole issue in this appeal based on the following statement in the Providers' Clarification letter:

> The Providers are not contending that the SSI tape sent by SSA to CMS contained individuals that failed to match with CMS's MedPAR file due to a flaw in the matching methodology or due to the use of a specific update of the MedPAR file, or for any of the other alleged errors in methodology that were argued in *Baystate.*[4]

Accordingly, the current case, PRRB Case No. 13-3117GC is hereby dismissed.

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:
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), 42 C.F.R. §§ 405.1868(a), 405.1875 and 405.1877.
cc: Wilson Leong, FSS

[4] Healthcare Reimbursement Services, Inc. July 31, 2018 letter, p. 1.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Certified Mail

AUG 0 6 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**
13-3091GC Indiana University Health 2008 DSH Medicare/Medicaid Part C Days CIRP
13-3528GC Beacon Health 2008 DSH Medicare/Medicaid Part C Days CIRP

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' July 30, 2018 request for expedited judicial review (EJR) (received July 31, 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]

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[1] The Representative also filed a request for EJR for the Hall Render 2015 Medicare/Medicaid Fraction Medicare Advantage Days Group, Case No. 17-1601G. Because that case involves FFY 2014, the FY 2014 IPPS Final Rule applies. *See* 78 Fed. Reg. 50496, 50615 (Aug. 19, 2013). Therefore, the EJR request for Case No. 17-1601G will be processed under separate cover.
[2] EJR Request at 1.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] These cases involve the 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]

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

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

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

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

Providers' Request for EJR

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

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[20] *Id.*
[21] 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).
[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] 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 underpayment 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 instructs it to do so.[27]

Decision of the Board

Board's Authority

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

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

All of the participants in Case Nos. 13-3091GC and 13-3528GC filed appeals of their original notices of program reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 12/31/2008.

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.*[28] 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.[29]

On August 21, 2008, new regulations governing the Board became effective.[30] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required that, 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).*[31] 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.[32]

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.

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[28] 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.).
[29] *Bethesda at 1258-59.*
[30] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[31] 201 F. Supp. 3d 131 (D.D.C. 2016)
[32] *Banner* at 142.

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

The Providers within this EJR request filed appeals with a cost reporting period ending 12/31/2008, thus the cost reporting period falls squarely within the time frame that covers the Secretary's final rule being challenged.[33] 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.[34]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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[33] 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 cost year 2008.

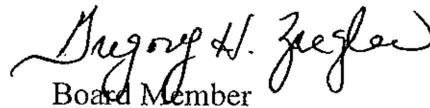
[34] *See* 863 Fed. 3d 937 (D.C. Cir. 2017).

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes case numbers 13-3091GC and 13-3528GC.

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, Wisconsin Physicians Service (Certified w/Schedules)
Wilson Leong, FSS (w/Schedules)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

AUG 0 6 2018

CERTIFIED MAIL

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

RE: Jurisdictional Decision

17-0880G QRS 2014 DSH Uncompensated Care Distribution Pool Group

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

This group appeal was established on January 23, 2017 with two Providers, one who was appealing from not timely receiving a Notice of Program Reimbursement ("NPR") and the other was appealing from an NPR. Other Providers were added to the group appeal, some that appealed from NPRs and another that appealed from a revised NPR.

The group appeal request identifies the following issue:

> The issue in this appeal involves CMS's calculations of the pool of uncompensated care ("UCC") payments available for distribution to Disproportionate Share Hospital ("DSH") eligible hospitals (i.e., the UCC Distribution Pool issue) as finalized in the 2014 Inpatient Prospective Payment System rulemaking on August 02, 2013.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue in case no. 17-0880G because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[1]

[1] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the

(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[2] upheld the D.C. District Court's decision[3] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[4] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[5]

The Board finds that the same findings are applicable to the Providers' challenge to their 2014 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for 2014. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in case no. 17-0880G because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes case no. 17-0880G and removes the appeal from its 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.

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estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

[2] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[2]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).

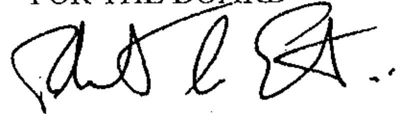
[3] 89 F. Supp. 3d 121 (D.D.C. 2015).

[4] 830 F.3d 515, 517.

[5] *Id.* at 519.

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 C. Leong Esq., FSS
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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AUG 07 2018

CERTIFIED MAIL

David Sierra
Memorial Healthcare System
3501 Johnson Street
Hollywood, FL 33021

RE: Provider: Memorial Healthcare System FFY 2015 Uncompensated Care Pool Calculation CIRP
Provider Nos.: Various
FYE: 9/30/2015
Case No.: 15-1314GC

Dear Mr. Sierra,

The Provider Reimbursement Review Board (PRRB or Board) has reviewed the documents in the above-referenced group appeals. The Board finds that it does not have jurisdiction over the uncompensated care disproportionate share hospital (DSH) payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

Background

On February 2, 2015, the Providers in the above-referenced group appeal filed a group appeal request with the Board from the August 22, 2014 Final Rules setting forth the federal fiscal years (FFY) 2015 Inpatient Prospective Payment System (IPPS) rates.[1] The Providers challenge CMS' calculation of the pool of uncompensated care payments available for distribution to DSH hospitals as finalized in the 2015 IPPS rulemaking.

The Providers contend CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the uncompensated care payments available for distribution to DSH eligible hospitals in its calculation of Factors 1 and 2 (the distribution pool). The Providers maintain CMS' determination of the distribution pool was beyond its authority, *ultra vires*. Thus, the preclusion of review provision found in the Social Security Act § 1886(r)(3) does not apply.

The Providers argue CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act. The Providers contend CMS failed to provide sufficient information regarding its calculation of the proposed distribution pool to allow for the presentation of relevant comments by the Providers. The Providers assert CMS specifically acknowledged in the final rule that the distribution pool was lower than the commenters may have expected due to the assumption that the expansion population is healthier than the rest of the Medicaid population and will utilize fewer hospital services. The Providers argue this assumption is not supported

[1] 79 Fed. Reg. 49854, 50,008-22 (Aug. 22, 2014).

by any evidence and was not disclosed until the final rulemaking, thereby entirely depriving the Providers the right to challenge the assumption or to offer countervailing arguments.[2]

The Providers maintain while the preclusion of review provision may protect the substance of CMS' determinations from review, it does not give CMS *carte blanche* to disregard the procedural safe-guards established for how CMS arrives at those determinations. The Providers contend the preclusion of review provision is not an invitation for CMS to regulate by foregoing notice and comment rulemaking.

The Providers assert CMS also acted beyond its authority in failing to adhere to the binding decision of the District of Columbia Circuit Court in *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014). The Providers contend the 2011 baseline number employed by CMS in calculating the distribution pool is significantly understated because in contravention of the D.C. Circuit's holding in *Allina*, it continues to systematically treat patient days paid under Part C as days entitled to benefits under Part A, which results in a significant reduction to the distribution pool. The Providers argue since CMS is using 2011 as the baseline period, and in 2011 there was no valid agency policy of treating patient days paid under Part C as days entitled to benefits under Part A, CMS was obligated to correct that baseline number to conform to the court's binding determination in *Allina*. The Providers contend the 2011 baseline was calculated in reliance on CMS' policy of treating patient days paid under Part C as days entitled to benefits under Part A; *Allina* has specifically held that that policy is null and void. As such, CMS has acted beyond its authority by violating a binding determination of the judicial branch.[3]

Board's Decision

The Board finds that it does not have jurisdiction over the uncompensated care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff (individual appeals) and 1395oo (Board appeals) for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[4]

(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court in *Tampa General*[5] upheld the D.C. District Court's decision[6] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for FFY 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital

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[2] Providers' Group Appeal Requests at 1-2.
[3] *Id.* at 3.
[4] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634 (August 19, 2013).
[5] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*, 830 F.3d 515, 517-18 (D.C. Cir. 2016).
[6] 89 F. Supp. 3d 121 (D.D.C. 2015).

cost data updated in March 2013, instead of data updated in April 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of *Tampa General's* claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[7] The Circuit Court also rejected *Tampa General's* argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[8]

The Circuit Court also found *Tampa General's* argument that because the statute directs the Secretary to base her estimates on appropriate data, any estimate based on inappropriate data is *ultra vires* unpersuasive. The Court noted to challenge agency action on the ground that it is *ultra vires, Tampa General* must show a patent violation of agency authority. The Court found the Secretary's choice of data is not obviously beyond the terms of the statute; and by asking the Court to review the appropriateness of the data the Secretary used to calculate *Tampa General's* DSH payment, the Provider is asking the Court to engage in the kind of case-by-case review of the reasonableness or procedural propriety of the Secretary's individual applications that Congress intended to bar.[9]

The Board finds that the same findings are applicable to the Providers' challenge to their 2015 uncompensated care payments. Similar to *Tampa General*, the Providers here are challenging CMS' calculation of the size of the pool of uncompensated care payments available for distribution. The Providers maintain CMS' determination of the distribution pool was beyond its authority, *ultra vires*. In challenging CMS' calculation of the uncompensated care distribution pool, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their payment amounts. Although the Providers here are challenging additional parts of the uncompensated care calculation (Part C days) than in *Tampa General*, they are still challenging the underlying data.

The Board finds that it does not have jurisdiction over the uncompensated care DSH issue in the above- referenced group appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the uncompensated care DSH issue is the only issue in this appeal, case number 15-1314GC is hereby closed and removed from the Board's docket.[10]

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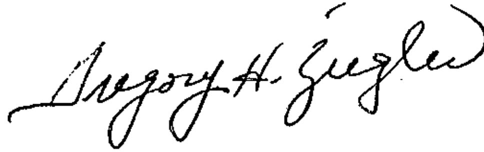
[7] 830 F.3d 515, 517.
[8] *Id.* at 519.
[9] *Id.* at 522.
[10] As the appeal is being dismissed in its entirety on subject matter jurisdiction, the Board is not attaching the Schedule of Providers for the group appeal to the decision.

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

FOR THE BOARD



Board Member

cc: Wilson Leong, Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

AUG 07 2018

CERTIFIED MAIL

Michelle Carrothers
OSF Healthcare System
800 North East Glen Oak Avenue
Peoria, IL 61603

RE: Provider: OSF HC FFY 2015 Uncompensated Care Pool Calculation CIRP Group
Provider Nos.: Various
FYE: 9/30/2015
Case No.: 15-1197GC

Dear Ms. Carrothers,

The Provider Reimbursement Review Board (PRRB or Board) has reviewed the documents in the above-referenced group appeals. The Board finds that it does not have jurisdiction over the uncompensated care disproportionate share hospital (DSH) payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

Background

On January 28, 2015, the Providers in the above-referenced group appeal filed a group appeal request with the Board from the August 22, 2014 Final Rules setting forth the federal fiscal years (FFY) 2015 Inpatient Prospective Payment System (IPPS) rates.[1] The Providers challenge CMS' calculation of the pool of uncompensated care payments available for distribution to DSH hospitals as finalized in the 2015 IPPS rulemaking.

The Providers contend CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the uncompensated care payments available for distribution to DSH eligible hospitals in its calculation of Factors 1 and 2 (the distribution pool). The Providers maintain CMS' determination of the distribution pool was beyond its authority, *ultra vires*. Thus, the preclusion of review provision found in the Social Security Act § 1886(r)(3) does not apply.

The Providers argue CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act. The Providers contend CMS failed to provide sufficient information regarding its calculation of the proposed distribution pool to allow for the presentation of relevant comments by the Providers. The Providers assert CMS specifically acknowledged in the final rule that the distribution pool was lower than the commenters may have expected due to the assumption that the expansion population is healthier than the rest of the Medicaid population and will utilize fewer hospital services. The Providers argue this assumption is not supported

[1] 79 Fed. Reg. 49854, 50,008-22 (Aug. 22, 2014).

by any evidence and was not disclosed until the final rulemaking, thereby entirely depriving the Providers the right to challenge the assumption or to offer countervailing arguments.[2]

The Providers maintain while the preclusion of review provision may protect the substance of CMS' determinations from review, it does not give CMS *carte blanche* to disregard the procedural safe-guards established for how CMS arrives at those determinations. The Providers contend the preclusion of review provision is not an invitation for CMS to regulate by foregoing notice and comment rulemaking.

The Providers assert CMS also acted beyond its authority in failing to adhere to the binding decision of the District of Columbia Circuit Court in *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014). The Providers contend the 2011 baseline number employed by CMS in calculating the distribution pool is significantly understated because in contravention of the D.C. Circuit's holding in *Allina*, it continues to systematically treat patient days paid under Part C as days entitled to benefits under Part A, which results in a significant reduction to the distribution pool. The Providers argue since CMS is using 2011 as the baseline period, and in 2011 there was no valid agency policy of treating patient days paid under Part C as days entitled to benefits under Part A, CMS was obligated to correct that baseline number to conform to the court's binding determination in *Allina*. The Providers contend the 2011 baseline was calculated in reliance on CMS' policy of treating patient days paid under Part C as days entitled to benefits under Part A; *Allina* has specifically held that that policy is null and void. As such, CMS has acted beyond its authority by violating a binding determination of the judicial branch.[3]

Board's Decision

The Board finds that it does not have jurisdiction over the uncompensated care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff (individual appeals) and 1395oo (Board appeals) for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[4]

(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court in *Tampa General*[5] upheld the D.C. District Court's decision[6] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for FFY 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital

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[2] Providers' Group Appeal Requests at 1-2.
[3] *Id.* at 3.
[4] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634 (August 19, 2013).
[5] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*, 830 F.3d 515, 517-18 (D.C. Cir. 2016).
[6] 89 F. Supp. 3d 121 (D.D.C. 2015).

cost data updated in March 2013, instead of data updated in April 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of *Tampa General's* claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[7] The Circuit Court also rejected *Tampa General's* argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[8]

The Circuit Court also found *Tampa General's* argument that because the statute directs the Secretary to base her estimates on appropriate data, any estimate based on inappropriate data is *ultra vires* unpersuasive. The Court noted to challenge agency action on the ground that it is *ultra vires, Tampa General* must show a patent violation of agency authority. The Court found the Secretary's choice of data is not obviously beyond the terms of the statute; and by asking the Court to review the appropriateness of the data the Secretary used to calculate *Tampa General's* DSH payment, the Provider is asking the Court to engage in the kind of case-by-case review of the reasonableness or procedural propriety of the Secretary's individual applications that Congress intended to bar.[9]

The Board finds that the same findings are applicable to the Providers' challenge to their 2015 uncompensated care payments. Similar to *Tampa General*, the Providers here are challenging CMS' calculation of the size of the pool of uncompensated care payments available for distribution. The Providers maintain CMS' determination of the distribution pool was beyond its authority, *ultra vires*. In challenging CMS' calculation of the uncompensated care distribution pool, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their payment amounts. Although the Providers here are challenging additional parts of the uncompensated care calculation (Part C days) than in *Tampa General*, they are still challenging the underlying data.

The Board finds that it does not have jurisdiction over the uncompensated care DSH issue in the above-referenced group appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the uncompensated care DSH issue is the only issue in this appeal, case number 15-1197GC is hereby closed and removed from the Board's docket.[10]

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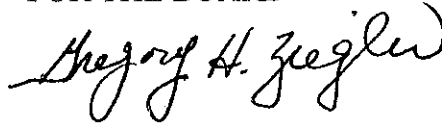
[7] 830 F.3d 515, 517.
[8] *Id.* at 519.
[9] *Id.* at 522.
[10] As the appeal is being dismissed in its entirety on subject matter jurisdiction, the Board is not attaching the Schedule of Providers for the group appeal to the decision.

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

FOR THE BOARD



Board Member

cc: Wilson Leong, Federal Specialized Services
Danene Hartley, National Government Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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AUG 0 7 2018

CERTIFIED MAIL

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

RE: Jurisdictional Decision

16-1994GC	QRS Providence Health 2014 DSH Uncompensated Care Payment CIRP Group
17-0810GC	QRS BSWH 2014 DSH Uncompensated Care Distribution Pool (Late Issuance of NPR) CIRP Group
17-1550GC	QRS Multicare 2014 DSH Uncompensated Care Payments CIRP Group
18-1224GC	QRS Asante Health 2014 Uncompensated Care Distribution Pool CIRP Group
18-1261G	QRS 2014 DSH Uncompensated Care Distribution Pool Group

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeals and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The Providers in case no. 16-1994GC; 17-1550GC; 18-1224GC; and 18-1216G filed their appeal requests with the Board from Notices of Program Reimbursement ("NPR"). Some of the Providers in case no. 17-0810GC appealed from the not timely issuance of NPRs and other Providers appealed from NPRs.

The Providers contend that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available to Disproportionate Share Hospital ("DSH") eligible hospitals therefore the preclusion of review provision found in the Social Security Act at § 1886(r)(3) does not apply.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue in the above-referenced appeals because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[1]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[2] upheld the D.C. District Court's decision[3] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[4] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[5]

The Board finds that the same findings are applicable to the Providers' challenge to their 2015 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for 2015. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in the above referenced group appeals because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in each appeal, the Board hereby closes the above-referenced group appeals and removes them from its docket.

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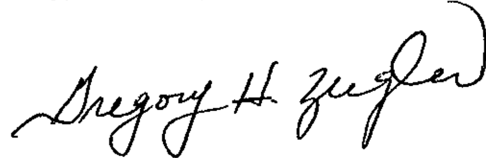
[1] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[2] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[2]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[3] 89 F. Supp. 3d 121 (D.D.C. 2015).
[4] 830 F.3d 515, 517.
[5] *Id.* at 519.

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
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

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AUG 07 2018

CERTIFIED MAIL

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

RE: Jurisdictional Decision
QRS Quorum 2014 DSH Uncompensated Care Distribution Pool CIRP Group
PRRB Case No. 18-0565GC

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts

The Providers in this group appeal all filed their appeal requests from Notices of Program Reimbursement ("NPR").

The Providers argue that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals.

Medicare Contractor's Arguments

The Medicare Contractor filed a jurisdiction challenge with the Board which argues that, although the Board has jurisdiction to determine if it has authority to hear the Providers' appeal, the statute at 42 U.S.C. § 1395ww(r)(3) bars administrative review, which means the Board is without authority to decide the issues raised by the Providers. The Medicare Contractor explains that the statute bars administrative or judicial review of any estimate of the Secretary for purposes of determining the factors described, which is what the Providers are contesting in this appeal. The Jurisdictional Challenge goes on to argue that each of the Providers' arguments cannot be reviewed under the statute and concludes that the Board does not have jurisdiction over the group issue.

Providers' Arguments

The Providers respond that the Medicare Contractor is incorrect in its jurisdictional challenge for several reasons: first, the statute does not authorize the Secretary to estimate the uninsured patient population percentage. Second, the Board may review the Secretary's estimates because the federal courts may also conduct such a review because the Providers are entitled to a writ of mandamus directing the

Secretary to revise the estimates and the statute does not preclude challenges to the regulation and policies relied upon by the Secretary in the computation. Last, the Providers argue that a failure to permit mandamus relief will result in "serious" constitutional issues.

Board's Decision

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue in case no. 18-0565GC because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[1]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[2] upheld the D.C. District Court's decision[3] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General,* the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[4] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[5]
The Board finds that the same findings are applicable to the Providers' challenge to their 2014 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for 2014. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data

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[1] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[2] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[2]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[3] 89 F. Supp. 3d 121 (D.D.C. 2015).
[4] 830 F.3d 515, 517.
[5] *Id.* at 519.

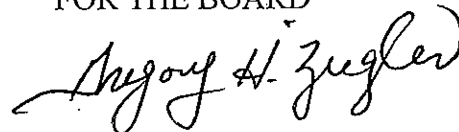
relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in the case no. 18-0565GC because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes case no. 18-0565GC and removes the appeal from its 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
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

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AUG 08 2018

Certified Mail

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RE: Memorial Hospital for Cancer and Allied Diseases, Inc.
Provider No. 33-0154
FYE 12/31/2011
PRRB Case No. 18-0220

Dear Mr. Jacob:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's July 27, 2018 request for expedited judicial review ("EJR") (received July 30, 2018) in the above referenced appeal. The Board may grant EJR if it has jurisdiction over the issue but lacks the authority to decide the specific legal question in dispute. The Board hereby grants EJR for the issue of the Provider's understated outpatient payment-to-cost ratio. The Board's decision is set forth below.

Background

The Provider filed an individual appeal request with the Board on November 14, 2017, establishing Case No. 18-0220. One of the issues in dispute is defined as follows:

> Provider's Understated Outpatient Payment-to-Cost Ratio
>
> This issue involves whether Cahaba [the Medicare Contractor] improperly failed to apply the cancer hospital payment adjustment required under Section 1833(t)(18) of the Social Security Act in determining payments due the Provider under the outpatient prospective payment system ("OPPS") for services furnished on or after January 1, 2011.[1]

Section 3138 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 ("ACA") amended the OPPS statute, in subsection 1833(t) of the Act, by adding a new paragraph 18 requiring a payment adjustment for certain cancer hospitals "described in section 1886(d)(1)(B)(v) of the Social Security Act," which includes the Provider. As amended by ACA, the statute required the Secretary to perform a study of the costs incurred by 11 cancer hospitals identified by statute to determine if the costs of services paid under

[1] Provider's Individual Appeal Request Tab 3E at 1, Nov. 14, 2017.

OPPS exceeded the costs incurred by other hospitals for those services.[2] The statute also mandated that the Secretary "shall provide for an appropriate adjustment" to the payments made to the 11 cancer hospitals if the Secretary were to determine that the hospitals' costs exceeded the costs incurred by other hospitals.[3] The statute stated that the Secretary "shall reflect those higher costs effective for services furnished on or after January 1, 2011."[4]

In 2010, the Secretary performed a study and determined that the 11 cancer hospitals' costs significantly exceeded the costs incurred by other hospitals.[5] Accordingly, the Secretary proposed a payment adjustment that would increase OPPS payments to cancer hospitals. However, the Secretary did not finalize the adjustment until November 30, 2011 ("2012 OPPS Final Rule").

The 2012 OPPS Final Rule states, "because the many public comments we received identified a broad range of very important issues and concerns associated with the proposed cancer hospital payment adjustment, we determined that further study and deliberation was necessary and, therefore, we did not finalize the CY [calendar year] 2011 proposed payment adjustment for certain cancer hospitals."[6] The Secretary made the payment adjustment effective as of January 1, 2012.[7] The 2012 OPPS Final Rule states, "[w]ith regard to the implementation date for the cancer hospital payment adjustment, the agency did not finalize the proposed cancer hospital adjustment for CY 2011 for a variety of reasons . . . " (namely, to consider the comments submitted; because the study was not finalized until November 2011; and, due to the statute's budge neutrality requirement).[8]

The Provider argues that the Secretary's one year delay in implementing the payment adjustment is contrary to law because the ACA set a specific implementation date. The Provider further argues that the Secretary's determination not to implement the payment adjustment by January 1, 2011 is arbitrary, capricious and contrary to law.[9] The Provider requests that the Board grant its request for EJR because the Board lacks the authority to decide the validity of the agency rule delaying the effective date of the OPPS payment adjustment as adopted in 75 Fed. Reg. 71800 (Nov. 24, 2010), 76 Fed. Reg. 74122 (Nov. 30, 2011), and 42 C.F.R. § 419.43(i)(1) (2012).[10]

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[2] Social Security Act § 1833(t)(18)(A), 42 U.S.C. § 1395l(t)(18)(A).
[3] § 1833(t)(18)(B), 42 U.S.C. § 1395l(t)(18)(B).
[4] *Id.*
[5] 75 Fed. Reg. 46170, 46233-34 (Proposed Rule Aug. 3, 2010).
[6] 76 Fed. Reg. 74121, 74202 (Final Rule Nov. 30, 2011).
[7] *Id.*
[8] *Id.* at 74205.
[9] Individual Appeal Request Tab 3E at 2.
[10] Provider's Petition for Expedited Judicial Review ("EJR Request") at 1 (Jul. 30, 2018).

Board Determination

The Board is required to issue an EJR pursuant to 42 C.F.R. § 405.1842(1) if:

(i) The Board has jurisdiction to conduct a hearing on the specific matter at issue in accordance with §405.1840 of this subpart.

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

Jurisdiction

A provider has a right to a Board hearing only if (1) it preserved its right to claim dissatisfaction with a final determination; (2) the amount in controversy is $10,000.00 or more; and (3) the appeal is filed within 180 days after the date of receipt of the final determination in dispute.[11] In this case, the Board finds that the Provider's appeal was filed timely (the Provider's Notice of Program Reimbursement ("NPR") was issued on May 19, 2017 and the appeal was received on November, 14, 2017). The Board also finds that the appeal meets the amount in controversy ($31,880,733 estimated for this issue alone) requirement. Further, the Provider preserved its right to claim dissatisfaction with a final determination when it protested the Payment to Cost Ratio on its cost report.[12] The Medicare Contractor made an audit adjustment (#10) to remove the protested amount.[13]

Additionally, CMS Ruling 1727-R applies to this case because it is for a cost reporting period ending on or after December 31, 2008 and before January 1, 2016, and the appeal was pending as of April 23, 2018.[14] Pursuant to CMS Ruling 1727-R, if a cost is non-allowable but the Provider protested the cost, then the Board has jurisdiction (assuming the timeliness and amount in controversy requirements are met).[15] Here, the cancer hospital payment adjustment was not in effect for 2011, so the Board finds that it was a non-allowable cost. Therefore, the Board determines that it has jurisdiction.

EJR

The second step is for the Board to determine whether it has the authority to decide this case. The Provider challenges the Secretary's delayed implementation of the cancer hospital payment adjustment, which is a legal challenge to the procedural and substantive validity of the regulation at 42 C.F.R. § 419.43(i)(1). This regulation provides:

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[11] *See* 42 C.F.R. § 405.1835(a).
[12] *See generally* Individual Appeal Request.
[13] *See id.*
[14] CMS Ruling 1727-R (Apr. 23, 2018).
[15] CMS Ruling 1727-R at 7.

> (i) Payment adjustment for certain cancer hospitals—(1) General rule. CMS provides for a payment adjustment for covered hospital outpatient department services furnished on or after January 1, 2012, by a hospital described in section 1886(d)(1)(B)(v) of the Act.

The Board finds that the challenge to the implementation date of the OPPS payment adjustment for certain cancer hospitals (required under Section 3138 of the Affordable Care Act) as contrary to the Social Security Act falls outside of its authority. The Board finds that:

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

2) based upon the Provider's assertions, there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 U.S.C. § 1395*l*(t)(18) and 42 C.F.R. § 419.43(i)(1)); and,

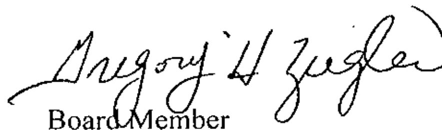
4) it is without the authority to decide the legal question of whether the implementation date of the OPPS Payment Adjustment for Certain Cancer Hospitals (required under Section 3138 of the Affordable Care Act) violates the Social Security Act.

Accordingly, the Board hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Case No. 18-0220 will remain open with the Board, however, since there are other issues in the case.

Board Members Participating

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

FOR THE BOARD:



Board Member

cc: Pam VanArsdale, NGS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

AUG 0 8 2018

CERTIFIED MAIL

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

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

RE: Merit Health Rankin
Provider No. 25-0096
FYE 12/31/2014
PRRB Case No. 17-1729

Dear Mr. Summar 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

Merit Health Rankin is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in an Original Notice of Program Reimbursement (NPR) dated December 21, 2016. The Provider timely filed an appeal from the NPR on June 20, 2017. The Model Form A- Individual Appeal Request presented eleven issues:

1. DSH Payment Supplemental Security income (SSI) Percentage (Provider Specific)
2. DSH /SSI (Systemic Errors)
3. DSH SSI Fraction/ Medicare Managed Care Part C Days
4. DSH SSI Fraction/ Dual Eligible Days
5. DSH Medicaid Fraction/ Medicare Managed Care Part C Days
6. DSH Medicaid Fraction/ Dual Eligible Days
7. DSH Medicaid Eligible Days
8. DSH Medicare Managed Care Part C Days
9. DSH Dual Eligible Days
10. Uncompensated Care ("UCC") Distribution Pool;
11. 2 Midnight Census IPPS Payment Reduction

On February 21, 2018, the Board received transfer requests from the Provider for the following issues:

- Issue 2: Supplemental Security Income Percentage to Case No.: 17-0578GC;
- Issue 3: SSI Fraction/Medicare Managed Care Part C Days to Case No.: 17-0576GC;
- Issue 4: DSH SSI Fraction/Dual Eligible Days to Case No.: 17-0575GC;
- Issues 5 & 8: Medicaid Fraction/Medicare Managed Care Part C Days to Case No.: 17-0574GC;
- Issues 6 & 9: Medicaid Fraction/Dual Eligible Days Group to Case No.: 17-0577GC;
- Issue 10: UCC Distribution Pool to Case No.: 17-0573GC;
- Issue 11: 2 Midnight Census IPPS Payment Reduction to Case No.: 17-0572GC.

Two issues remain pending in the Provider's individual appeal: the SSI Provider Specific and Medicaid Eligible Days. The Medicaid Contractor submitted a jurisdictional challenge over several issues in the appeal.

Medicare Contractor Contentions

The Medicare Contractor has challenged jurisdiction over 5 issues: SSI Provider Specific; Medicaid Eligible Days; Medicare Managed Care Part C Days; Dual Eligible Days; and UCC Distribution Pool.

SSI Provider Specific

The Medicare Contractor argues that the Board does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue and is an issue that is suitable for reopening, but it is not an appealable issue.[1] The Medicare Contractor goes on to explain that in the context of an SSI realignment request, it has not made a final determination with which a Provider could be dissatisfied, therefore the Board does not have jurisdiction pursuant to 42 C.F.R. § 405.1835. The Medicare Contractor concludes that the Provider cannot appeal the realignment of its SSI percentage or try to leverage its appeal regarding the validity of the SSI percentage by including the realignment as an appeal issue.[2]

Medicaid Eligible Days

The Medicare Contractor argues that adjustments 7, 25 and 27, to which the Provider cited as a source of dissatisfaction, do not render a final determination with respect to additional Medicaid Eligible days. Adjustment 27 updated the SSI ratio and adjustment 7 updates worksheet S-3, part 1 to reflect the Providers PS+R. The Provider also cites to adjustment 25 which removed protested amounts, but eligible days weren't protested on the protest worksheet.[3]

Medicare Managed Care Part C Days and Dual Eligible Days

The Medicare Contractor contends that Issue 8, Medicare Managed Care Part C Days, is duplicative of Issues 3 and 5, the SSI and Medicaid fraction Part C Days issues. The Medicare

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[1] Medicare Contractor's Jurisdictional Challenge at 2-3.
[2] *Id.* at 4.
[3] *Id.*

Contractor also contends that Issue 9, Dual Eligible days, is duplicative of Issues 4 and 6, the SSI and Medicaid fraction Dual Eligible Days issues.[4]

UCC Distribution Pool

The Medicare Contractor also challenged jurisdiction over the uncompensated care issue, however that issue was transferred to a group appeal on February 21, 2018, therefore the Board will not address this issue in the Provider's individual appeal.

Provider's Contentions

SSI Provider Specific

The Provider contends that the Medicare Contractor is incorrect when arguing that the DSH/SSI realignment issue is not an appealable issue.[5] 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.[6] 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.[7]

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).[8] The decision that was abandoned was that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS.[9] Thus, the Provider reasons that it can submit data to prove its SSI percentage was understated.

Medicaid Eligible Days

The Provider argues that the Board has jurisdiction over the Medicaid Eligible Days issue because there was an adjustment to the DSH on its cost report, which is enough to warrant jurisdiction. The Provider also argues that DSH does not have to be adjusted or claimed on a cost report. It also cites to delays in receiving information from the state as a "practical impediment."[10]

Medicare Part C and Dual Eligible Days Duplicate Issues

The Provider agrees that there are duplicate issues and requests that Issue 5 be consolidated with Issue 8 and that Issue 6 be consolidated with Issue 9.[11]

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[4] *Id.* at 4-5.
[5] Provider's Jurisdictional Response at 2.
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] *Id.* at 3.
[11] *Id.* at 12.

Board's Decision

SSI Provider Specific

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 the Provider transferred to case no. 17-0578GC and is therefore dismissed by the Board.[12] 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."[13] The Provider's legal basis for its 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)."[14] 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."[15]

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 been transferred into a group appeal.

Because the Systemic Errors issue was transferred to a group, the Board hereby dismisses this aspect of the SSI Provider Specific issue from case no. 17-1729.

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

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue and dismisses the issue from case no. 17-1729.

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[12] *See* Provider's Individual Appeal Request at Tab 3.
[13] *Id.* at Tab 3, Issue 1.
[14] *Id.*
[15] *Id.*

Issue 2 – Medicaid Eligible Days

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

At issue in this jurisdictional dispute is the dissatisfaction requirement for Board jurisdiction. Regulation dictates that a provider must preserve its right to claim dissatisfaction with the amount of Medicare payment for the specific items at issue, by either –

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

However, *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016) ("*Banner*") holds that a provider cannot be held to the claim preservation/presentment requirement of 42 C.F.R. § 405.1835(a)(1) when the provider is challenging a Medicare regulation or policy which the Medicare contractor has no authority to entertain or decide (such as a challenge to a Medicare regulation or policy).[16] The *Banner* court explained its decision as:

> [W]hen a provider fails to present a claim in its cost report that [a Medicare contractor] can address, it can be deemed "satisfied" with the amounts requested in the cost report and awarded by the [Medicare contractor]. But where the [Medicare contractor] has no authority to address a claim, such as when a pure legal challenge to a regulation is at issue, a provider cannot be deemed to be "satisfied" simply because such challenge is not reflected in the cost report. Satisfaction cannot be imputed from a provider's silence when everyone knows that it would be futile to present such claim to the [Medicare contractor].

The *Banner* court looked to *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) ("*Bethesda*") which also addressed a challenge to a regulation which was not first presented to the Medicare contractor.[17] *Bethesda* holds that a provider need not protest self-disallowed costs that are barred from being claimed because of a specific statute, regulation, or ruling.[18]The Supreme Court in *Bethesda* stated:

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[16] 42 C.F.R. 405.1835(a)(1)(2013).
[17] *Banner* at 141.
[18] *Bethesda Hosp. Ass'n v. Bowen,* 485 U.S. 399 (1988) at 404.

> [T]he submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the [Contractor]. Providers know that, under the statutory scheme, the [Contractor] is confined to the mere application of the Secretary's regulations that the [Contractor] is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the [Contractor] to do otherwise would be futile.

CMS recently issued Ruling CMS-1727-R ("Ruling 1727") to state its policy to follow the holding in *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016). Ruling 1727 sets out a five-step analysis for the Board to undertake to determine whether a provider is entitled to a PRRB hearing for an item that the provider appealed but did not include on its cost report. In short, a provider has a right to a PRRB hearing for such an item if it excluded the item based upon "a good faith belief that the item was subject to a payment regulation or other policy that gave the Medicare contractor no authority or discretion to make payment in the manner the provider sought."[19]

Analysis of the DSH Medicaid Eligible Days Under Ruling 1727

The first step of analysis under Ruling 1727 involves the appeal's filing date and cost reporting period. The appeal must have been pending or filed after the Ruling was issued on April 23, 2018. In the instant case, the Board received the Provider's request for hearing on June 20, 2017 and the appeal was open on April 23, 2018, thus it satisfies the appeal pending date requirement. Additionally, the Ruling applies to appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016. This appeal involves a fiscal year end December 31, 2014 cost report, thus the appealed cost reporting period falls within the required time frame.

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."[20]

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 DSH 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 claimed…and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." 42 C.F.R. § 412.106(b)(4)(iii) (2010).

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[19] Ruling 1727 at unnumbered page 2.

[20] Ruling 1727 at 6.

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 could find that the Provider's DSH Medicaid Eligible Days 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."

The third, fourth and fifth steps of analysis under Ruling 1727 involve the Board's assessment of whether a provider's appeal has met the jurisdictional requirements set out in the applicable regulation.[21] As the Provider's appeal was timely filed and the estimated amount in controversy is over $10,000, the first two Board jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, Ruling 1727 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, the DSH Medicaid Eligible Days sought are <u>not</u> within the payment authority or discretion of the Medicare Contractor because Provider could not prove or verify eligibility with the State in time to include the Days on the Provider's cost report, as required by regulation.

Under step four of Ruling 1727, the Board does not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable) if a determination has been made that the item under appeal was subject to a regulation or other policy that bound the Medicare Contractor and left it with no authority or discretion to make payment as sought. As discussed in step two above, these DSH Medicaid Eligible Days are "non-allowable" costs because the Medicare Contractor was bound by the proof of eligibility regulation at 42 C.F.R. § 412.106(b)(4)(iii), and it is recommended that the Board "not apply the self-disallowance jurisdiction regulation" in its jurisdictional decision.

Under step five of Ruling 1727, the Board is directed to consider the circumstances surrounding a provider's self-disallowance claim. In the instant appeal, however, the Provider did not self-disallow the DSH Medicaid Eligible Days issue, thus this step is not applicable to this appeal.

The Board finds that the DSH Medicaid Eligible Days issue is within the Board's jurisdiction, based upon the *Banner* rationale and Ruling 1727-R, as it would have been futile to present DSH Medicaid Eligible Days to the Medicare Contractor without proof of eligibility and State verification. However, Board make it clear that only those DSH Medicaid Eligible Days which were not able to be verified prior to the cost report filing date are subject to the Board's jurisdiction under *Banner* and Ruling 1727-R, and that the Provider and the Medicare Contractor shall, based on information privy to these two parties, ascertain the DSH Medicaid Eligible Days that are subject to the Board's jurisdiction.

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[21] 42 C.F.R. § 405.1835(a) (2010).

Medicare Part C and Dual Eligible Days Duplicate Issues

The Board finds that Issue 5, Medicaid Fraction/Medicare Managed Care Days and Issue 8, Medicare Managed Care Days, are duplicative. The Board agrees to consolidate Issue 5 into Issue 8, which has been transferred to a group appeal, case no. 17-0574GC (QRS HMA 2014 DSH Medicaid Fraction Managed Care Part C Days Group. Similarly, the Board finds that Issue 6, Medicaid Fraction/Dual Eligible Days and Issue 9, Dual Eligible Days, are duplicative. The Board grants consolidation of Issue 6 into Issue 9, which has been transferred to a group appeal, case no. 17-0577GC, QRS HMA 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group.

Conclusion

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic errors issue transferred to a group and there is no final determination with respect to the realignment portion of the issue. The Board finds that it has jurisdiction over the Medicaid eligible days issue based on the rationale in *Banner*; particularly, it has jurisdiction over the days that could not be verified prior to the cost report filing.

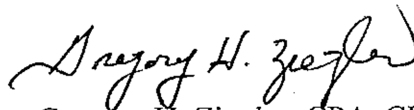
The Board grants consolidation over Issues 5 and 8 (Medicare Managed Care Part C Days) and Issues 6 and 9 (Dual eligible days) as they are duplicative issues. These issues were transferred to CN's 17-0574GC and 17-0577GC. The UCC Distribution Pool issue was transferred to a group appeal, so that challenge will not be addressed in this individual appeal.

Case no. 17-1729 will remain open as the Medicaid eligible days issue is still pending.

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 appeal.

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
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CERTIFIED MAIL

AUG 1 6 2018

Steve Hernandez
Tenet Healthcare Corporation
1445 Ross Avenue
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Dallas, TX 75202-2703

RE: Provider: Tenet FFY 2015 Uncompensated Care Pool Calculation Group
Provider Nos.: Various
FYE: 9/30/2015
Case No.: 15-1472GC

Dear Mr. Hernandez,

The Provider Reimbursement Review Board (PRRB or Board) has reviewed the documents in the above-referenced group appeal. The Board finds that it does not have jurisdiction over the uncompensated care disproportionate share hospital (DSH) payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

Background

On February 18, 2015, the Providers in the above-referenced group appeal filed a group appeal request with the Board from the August 22, 2014 Final Rules setting forth the federal fiscal years (FFY) 2015 Inpatient Prospective Payment System (IPPS) rates.[1] The Providers challenge CMS' calculation of the pool of uncompensated care payments available for distribution to DSH hospitals as finalized in the 2015 IPPS rulemaking.

The Providers contend CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the uncompensated care payments available for distribution to DSH eligible hospitals in its calculation of Factors 1 and 2 (the distribution pool). Thus, the preclusion of review provision found in the Social Security Act § 1886(r)(3) does not apply.

The Providers argue CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act. The Providers contend CMS failed to provide sufficient information regarding its calculation of the proposed distribution pool to allow for the presentation of relevant comments by the Providers. The Providers assert CMS specifically acknowledged in the final rule that the distribution pool was lower than the commenters may have expected due to the assumption that the expansion population is healthier than the rest of the Medicaid population and will utilize fewer hospital services. The Providers argue this assumption is not supported by any evidence and was not disclosed until the final rulemaking, thereby entirely depriving the Providers the right to challenge the assumption.[2]

[1] 79 Fed. Reg. 49854, 50,008-22 (Aug. 22, 2014).
[2] Providers' Group Appeal Requests at 1-2.

The Providers maintain while the preclusion of review provision may protect the substance of CMS' determinations from review, it does not permit CMS to blatantly disregard the procedural safeguards established for how CMS arrives at those determinations.

The Providers assert CMS also acted beyond its authority in failing to adhere to the binding decision of the District of Columbia Circuit Court in *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014). The Providers contend the 2011 baseline number employed by CMS in calculating the distribution pool is significantly understated because contrary to the D.C. Circuit's holding in *Allina*, it continues to systematically treat patient days paid under Part C as days entitled to benefits under Part A, which results in a significant reduction to the distribution pool. The Providers argue since CMS is using 2011 as the baseline period, and in 2011 there was no valid agency policy of treating patient days paid under Part C as days entitled to benefits under Part A, CMS was obligated to correct that baseline number to conform to the court's binding determination in *Allina*. By failing to do so, CMS acted beyond its authority by violating a binding determination of the judicial branch.[3]

Board's Decision

The Board finds that it does not have jurisdiction over the uncompensated care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff (individual appeals) and 1395oo (Board appeals) for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[4]

(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court in *Tampa General*[5] upheld the D.C. District Court's decision[6] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for FFY 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in April 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of *Tampa General's* claims because in challenging the use of the March 2013 update

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[3] *Id.* at 3.

[4] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634 (August 19, 2013).

[5] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*, 830 F.3d 515, 517-18 (D.C. Cir. 2016).

[6] 89 F. Supp. 3d 121 (D.D.C. 2015).

data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[7] The Circuit Court also rejected *Tampa General's* argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[8]

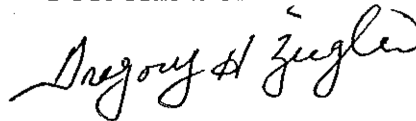
The Circuit Court also found *Tampa General's* argument that because the statute directs the Secretary to base her estimates on appropriate data, any estimate based on inappropriate data is *ultra vires* unpersuasive. The Court noted to challenge agency action on the ground that it is *ultra vires, Tampa General* must show a patent violation of agency authority. The Court found the Secretary's choice of data is not obviously beyond the terms of the statute; and by asking the Court to review the appropriateness of the data the Secretary used to calculate *Tampa General's* DSH payment, the Provider is asking the Court to engage in the kind of case-by-case review of the reasonableness or procedural propriety of the Secretary's individual applications that Congress intended to bar.[9]

The Board finds that the same findings are applicable to the Providers' challenge to their 2015 uncompensated care payments. Similar to *Tampa General*, the Providers here are challenging CMS' calculation of the size of the pool of uncompensated care payments available for distribution. The Providers maintain CMS' determination of the distribution pool was beyond its authority. In challenging CMS' calculation of the uncompensated care distribution pool, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their payment amounts. Although the Providers here are challenging additional parts of the uncompensated care calculation (Part C days) than in *Tampa General*, they are still challenging the underlying data.

The Board finds that it does not have jurisdiction over the uncompensated care DSH issue in the above- referenced group appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the uncompensated care DSH issue is the only issue in this appeal, case number 15-1472GC is hereby closed and removed from the Board's docket.[10]

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

FOR THE BOARD



Board Member

cc: Wilson Leong, Federal Specialized Services
Mounir Kamal, Novitas Solutions, Inc.

[7] 830 F.3d 515, 517.
[8] *Id.* at 519.
[9] *Id.* at 522.
[10] As the appeal is being dismissed in its entirety on subject matter jurisdiction, the Board is not attaching the Schedule of Providers for the group appeal to the decision.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
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CERTIFIED MAIL

AUG 1 6 2018

Stephen Nash
Squire Patton Boggs LLP
1801 California Street
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Denver, CO 80202

RE: Provider: Squire Patton Boggs Lee Memorial 2014 DSH Uncompensated Care CIRP and Squire Patton Boggs- Lee Health 2015 DSH Uncompensated Care CIRP Group
Provider Nos.: Various
FYEs: 09/30/2014, 9/30/2015
Case No: 16-2419GC, 17-2095GC

Dear Mr. Nash,

The Provider Reimbursement Review Board (PRRB or Board) has reviewed the documents in the above-referenced group appeal. The Board finds that it does not have jurisdiction over the uncompensated care disproportionate share hospital (DSH) payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

Background

On August 26, 2016, and August 23, 2017, the Providers in the above-referenced group appeals filed group appeal requests with the Board from untimely contractor determinations (no Notice of Program Reimbursements (NPRs)) pursuant to 42 C.F.R. § 405.1835(c). The Providers challenge the uncompensated care calculations used to determine their DSH payments.

The Providers contend the current Medicare Cost Report instructions related to Worksheet S-10 are ambiguous and could result in uncompensated care costs that are different from what is included in their cost reports. The Providers maintain there are potential errors associated with the published uncompensated care amounts reported on line 35 of Worksheet E Part A; however, CMS has not provided enough detail to be able to succinctly identify the error rate. The Providers assert they have included a protested amount as it relates to uncompensated care in order to preserve their future appeal rights pertaining to the cost of uncompensated care on Worksheet S-10.

The Providers maintain given the foregoing errors, the Medicare Contractor's uncompensated care calculations were inconsistent with the Congressional intent to reimburse hospitals for treatment of all indigent patients when determining DSH program eligibility and reimbursement. The Providers contend they are unable to determine whether their Medicare DSH payments are correct because they do not have access to all of the underlying information concerning the calculation of their payments. The Providers assert their appeal is not limited to challenging audit adjustments; the uncompensated care calculation issue is a challenge to the Secretary's underlying policy.[1]

[1] Providers'Group Appeal Requests Tab 2 at 1.

Board's Decision

The Board finds that it does not have jurisdiction over the uncompensated care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff (individual appeals) and 1395oo (Board appeals) for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[2]

(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court in *Tampa General*[3] upheld the D.C. District Court's decision[4] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for FFY 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in April 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of *Tampa General's* claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[5] The Court also rejected *Tampa General's* argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[6]

The Court also found *Tampa General's* argument that the statute creates no bar to a court reviewing the Secretary's ultimate decision as to the amount of a hospital's final DSH payment, but only the intermediate determination as to the estimate of a hospital's share of uncompensated care unpersuasive. The Court noted that this is a distinction without a difference. The Court stated the critical factor is not whether the statute barred from review the agency's ultimate determination or merely an intermediate step in reaching that decision. Rather, the Court found the dispositive issue is whether the challenged data are inextricably intertwined with an action that all agree is shielded from review, regardless of

[2] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634 (August 19, 2013).
[3] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*, 830 F.3d 515, 517-18 (D.C. Cir. 2016).
[4] 89 F. Supp. 3d 121 (D.D.C. 2015).
[5] 830 F.3d 515, 517.
[6] *Id.* at 519.

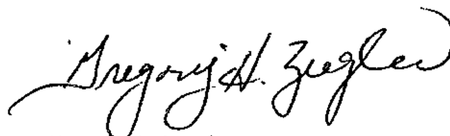
where that action lies in the agency's decision tree. The Court noted because the data is inextricably intertwined with the Secretary's estimate of uncompensated care, *Tampa General* cannot challenge the Secretary's choice of data in court.[7]

The Board finds that the same findings are applicable to the Providers' challenge to their 2014 and 2015 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for FYs 2014 and 2015. In challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. In essence, the Providers are challenging the underlying data relied on by the Secretary to obtain those final payment amounts. However, as the D.C. Circuit Court in *Tampa General* held, the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board finds that it does not have jurisdiction over the uncompensated care DSH issue in the above referenced group appeals because judicial and administrative review of the calculation is barred by statute and regulation. As the uncompensated care DSH issue is the only issue in these appeals, case numbers 16-2419GC and 17-2095GC are hereby closed and removed from the Board's docket.[8]

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

FOR THE BOARD



Board Member

cc: Wilson Leong, Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc.

[7] *Id.* at 521.

[8] As the appeals are being dismissed in their entirety on subject matter jurisdiction, the Board is not attaching the Schedule of Providers for these group appeals to the decision.

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AUG 21 2018

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P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Motion for Reconsideration of Jurisdictional Decision Regarding Additional Medicaid Eligible Days Verified After Submission of Cost Report

St. Luke's Hospital of Duluth
Provider. No. 24-0047
FYE 12/31/2008
PRRB Case No. 13-3675

Dear Mr. Miller and Ms. Hartley,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in case number 13-3675 in response to the Provider's Motion for Reconsideration. The Board denies the Provider's request. The decision is set forth below.

Background

On June 18, 2009, the Provider submitted its cost report, which included 5,888 Medicaid eligible days, to the Medicare Contractor.[1] On May 5, 2010, the Medicare Contractor emailed the Provider indicating that it would be disallowing 588 Medicaid eligible days because they needed to be verified by the State which would not be completed by the time the Medicare Contractor was required to complete the audit.[2]

On March 12, 2013, the Provider was issued an original Notice of Program Reimbursement ("NPR") for fiscal year end 12/31/2008. The Medicare Contractor removed 559 Medicaid eligible days in the NPR. The Provider filed its appeal request with the Board on September 9, 2013, and included Medicaid eligible days as one of the five issues it appealed.

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[1] Provider's Response to Jurisdictional Challenge at 5.
[2] Medicare Contractor's Jurisdictional Challenge, Exhibit I-3 at 4.

The Board received the Medicare Contractor's Jurisdictional Challenge over the Medicaid eligible days issue on November 22, 2016; the Provider responded on December 20, 2016. In its jurisdictional challenge, the Medicare Contractor indicated that it was **not** challenging jurisdiction over the 588 Wisconsin HMO days that were disallowed at audit and subsequently appealed.

The Board issued a jurisdictional determination on March 1, 2018, in which it denied jurisdiction over the Medicaid eligible days issue and closed the appeal. The Provider requested that the Board reconsider its determination with respect to a specific set of eligible days. The Board issued a decision on April 18, 2018 in which it granted reinstatement of the appeal and found that it has jurisdiction over the 588 Medicaid eligible days that the Provider initially claimed and that were disallowed at audit.

On April 23, 2018, CMS issued Ruling 1727-R based on the decision in *Banner Heart Hosp. v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016). On May 24, 2018, the Provider requested reconsideration of the Board's previous decisions in light of CMS Ruling 1727-R ("the Ruling").

Provider's Request for Reconsideration based on *Banner* and CMS Ruling 1727-R

The Provider has requested that the Board reconsider its March 1, 2018 decision in which it denied jurisdiction over additional Medicaid eligible days based on 42 C.F.R. § 405.18354(a). The Provider argues that in Ruling 1727-R, CMS has acquiesced to a federal court determination that the regulation cannot be applied in circumstances such as the Provider's FY 2008 appeal. The Provider then goes on to address the framework for applying the Ruling to the Additional Eligible days over which the Board has denied jurisdiction.

First, the Provider's appeal is from its 12/31/2008 cost reporting period and the appeal was pending on April 23, 2018, when the Ruling was issued. Second, the Ruling requires the Board to determine whether the specific item under appeal was subject to a regulation or policy that bound the Medicare Contractor. The Provider argues that pursuant to 42 C.F.R. § 412.106(b)(4)(iii), a provider is only allowed to provide data for Medicaid eligible patient days that have been verified by a state Medicaid agency. It continues that had it claimed the Additional Days (that were verified after it filed its cost report) when it filed its cost report, the Medicare Contractor would not have had the authority to make a payment for those days.[3]

Third, if the provider satisfies the first two requirements, the Board shall not apply the self-disallowance jurisdictional requirement. The Provider here argues that its appeal does satisfy the first two requirements, therefore the Board may not apply the self-disallowance requirement; the timeliness and amount in controversy requirements are satisfied.[4]

The Provider argues that, fourth, the Ruling is not an appropriate basis for the *reopening of a final determination by the Medicare Contractor.* [5] Therefore, a reopening of this decision is not in conflict with the ruling, as this decision is not a final determination. The Provider here is

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[3] Provider's May 23, 2018 Request for Reconsideration at 3.
[4] *Id.* at 3-4.
[5] *Id.* at 4, emphasis added.

requesting that the Board reinstate the Additional eligible days issue to the appeal.

Medicare Contractor's Position

FSS, on behalf of the Medicare Contractor, argues that the issue of Medicaid eligible days is not within the scope of *Banner* or CMS Ruling 1727-R. FSS characterizes the Medicaid eligible days issue as a documentation issue and contrasts that with the legal challenges to the validity of a regulation that were raised in both *Banner* and *Bethesda*. In those cases, the Medicare Contractor had "no authority or discretion to make payment in the manner the provider sought."[6] FSS distinguishes Medicaid eligible days because the Medicare Contractor does have the authority and discretion to make payment determinations over the number of Medicaid eligible days. Therefore, FSS concludes that the issue is outside the scope of *Banner* and CMS Ruling 1727-R.

FSS also argues that the Ruling is clear that the Ruling itself cannot be the basis for the reopening of any decision by the PRRB.[7]

Board's Decision

The Board denies the Provider's Motion for Reconsideration of Jurisdictional Decision Regarding Additional Medicaid Eligible Days Verified after Submission of Cost Report which was submitted in response to the issuance of CMS Ruling 1727-R. The Board finds that the Ruling prohibits it from reopening a jurisdictional determination. The Ruling states:

> Fifth, it is also CMS's Ruling that, under 42 CFR 405.1801(a) and 405.1885(c)(1) and (2), this Ruling is not an appropriate basis for the reopening of any final determination by a Medicare contractor or the Secretary or of any decision by the PRRB or other reviewing entity. Accordingly, it is hereby held that the Medicare contractors and the reviewing entities may not reopen **any** determination or **decision** with respect to the question of whether application of the self-disallowance jurisdictional requirement in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable, is foreclosed by any provision of this CMS Ruling.[8]

The Ruling was issued on April 23, 2018. Prior to the issuance of the Ruling, on March 1, 2018 and April 18, 2018, the Board issued jurisdictional decisions in which it initially denied jurisdiction over Medicaid eligible days, but then subsequently reopened the appeal and granted jurisdiction over 588 Medicaid eligible days. The Provider is now requesting that the Board reopen its jurisdictional decisions in order to grant jurisdiction over more Medicaid eligible days. The Board hereby denies this request because the Ruling states that it is not an appropriate basis for the reopening of any decision by "a reviewing entity", in this case the Board.

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[6] Medicare Contractor's Response to Reconsideration Request at 2 (dated June 7, 2018).
[7] *Id.* at 4.
[8] CMS Ruling 1727-R at unnumbered page 9 (April 23, 2018) (emphasis added).

PRRB Case No. 13-3675 remains open and is scheduled for hearing on September 28, 2018.

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 appeal.

Board Members:
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

cc: Wilson Leong, FSS

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RE: Motion for Reconsideration of Jurisdictional Decision Regarding Additional Medicaid Eligible Days Verified After Submission of Cost Report

St. Luke's Hospital of Duluth
Provider. No. 24-0047
FYE 12/31/2009
PRRB Case No. 14-1746

Dear Mr. Miller and Ms. Hartley,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdiction documents in case number 14-1746 in response to the Provider's Motion for Reconsideration. The Board denies the Provider's request. The decision is set forth below.

Background

On July 16, 2013, the Provider, St. Luke's Hospital of Duluth, was issued an original Notice of Program Reimbursement ("NPR") for fiscal year end 12/31/2009. The Provider filed an appeal request with the Board on January 14, 2014, in which it appealed five issues, including Medicaid eligible days, which is the only issue that remains pending in the appeal.[1]

The Medicare Contractor filed a jurisdictional challenge over the Medicaid eligible days issue on December 19, 2017; the Provider responded on January 12, 2018. On February 26, 2018, the Board issued a jurisdictional decision in which it found that it has jurisdiction over 195 Medicaid eligible days that were submitted at audit, but which the Medicare Contractor excluded.

On April 23, 2018, CMS issued Ruling 1727-R based on the decision in *Banner Heart Hosp. v.*

[1] The Board received the Provider's Final Position Paper on November 30, 2017, which stated that the sole issue before the Board is Medicaid eligible days.

Burwell, 201 F. Supp. 3d 131 (D.D.C. 2016). On May 24, 2018, the Provider requested reconsideration of the Board's previous decisions in light of CMS Ruling 1727-R ("the Ruling").

Provider's Request for Reconsideration based on *Banner* and CMS Ruling 1727-R

The Provider has requested that the Board reconsider its February 26, 2018 decision in which it denied jurisdiction over additional Medicaid eligible days based on 42 C.F.R. § 405.18354(a). The Provider argues that in Ruling 1727-R, CMS has acquiesced to a federal court determination that the regulation cannot be applied in circumstances such as the Provider's FY 2009 appeal. The Provider then goes on to address the framework for applying the Ruling to the Additional Eligible days over which the Board has denied jurisdiction.

First, the Provider's appeal is from its 12/31/2009 cost reporting period and the appeal was pending on April 23, 2018, when the Ruling was issued. Second, the Ruling requires the Board to determine whether the specific item under appeal was subject to a regulation or policy that bound the Medicare Contractor. The Provider argues that pursuant to 42 C.F.R. § 412.106(b)(4)(iii), a provider is only allowed to provide data for Medicaid eligible patient days that have been verified by a state Medicaid agency. It continues that had it claimed the Additional Days (that were verified after it filed its cost report) when it filed its cost report, the Medicare Contractor would not have had the authority to make a payment for those days.[2]

Third, if the provider satisfies the first two requirements, the Board shall not apply the self-disallowance jurisdictional requirement. The Provider here argues that its appeal does satisfy the first two requirements, therefore the Board may not apply the self-disallowance requirement; the timeliness and amount in controversy requirements are satisfied.[3]

The Provider argues that, fourth, the Ruling is not an appropriate basis for the *reopening of a final determination by the Medicare Contractor.*[4] Therefore, a reopening of this decision is not in conflict with the ruling, as this decision is not a final determination. The Provider here is requesting that the Board reinstate the Additional eligible days issue to the appeal.

Medicare Contractor's Position

FSS, on behalf of the Medicare Contractor, argues that the issue of Medicaid eligible days is not within the scope of *Banner* or CMS Ruling 1727-R. FSS characterizes the Medicaid eligible days issue as a documentation issue and contrasts that with the legal challenges to the validity of a regulation that were raised in both *Banner* and *Bethesda*. In those cases, the Medicare Contractor had "no authority or discretion to make payment in the manner the provider sought."[5] FSS distinguishes Medicaid eligible days because the Medicare Contractor does have the authority and discretion to make payment determinations over the number of Medicaid eligible days. Therefore, FSS concludes that the issue is outside the scope of *Banner* and CMS Ruling 1727-R.

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[2] Provider's May 23, 2018 Request for Reconsideration at 3.
[3] *Id.* at 3-4.
[4] *Id.* at 4, emphasis added.
[5] Medicare Contractor's Response to Reconsideration Request at 2 (dated June 7, 2018).

FSS also argues that the Ruling is clear that the Ruling itself cannot be the basis for the reopening of any decision by the PRRB.[6]

Board's Decision

The Board denies the Provider's Motion for Reconsideration of Jurisdictional Decision Regarding Additional Medicaid Eligible Days Verified after Submission of Cost Report which was submitted in response to the issuance of CMS Ruling 1727-R. The Board finds that the Ruling prohibits it from reopening a jurisdictional determination. The Ruling states:

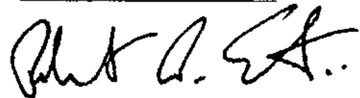
> Fifth, it is also CMS's Ruling that, under 42 CFR 405.1801(a) and 405.1885(c)(1) and (2), this Ruling is not an appropriate basis for the reopening of any final determination by a Medicare contractor or the Secretary or of any decision by the PRRB or other reviewing entity. Accordingly, it is hereby held that the Medicare contractors and the reviewing entities may not reopen **any** determination or **decision** with respect to the question of whether application of the self-disallowance jurisdictional requirement in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable, is foreclosed by any provision of this CMS Ruling.[7]

The Ruling was issued on April 23, 2018. Prior to the issuance of the Ruling, on February 26, 2018, the Board issued a jurisdictional decision in which it granted jurisdiction over 195 Medicaid eligible days that were submitted at the time of audit, but which the Medicare Contractor excluded; the Board denied jurisdiction over other additional Medicaid eligible days that have since been identified. The Provider is now requesting that the Board reopen its jurisdictional decision in order to grant jurisdiction over more Medicaid eligible days. The Board hereby denies this request because the Ruling states that it is not an appropriate basis for the reopening of any decision by "a reviewing entity", in this case the Board.

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 appeal.

Board Members:
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

cc: Wilson Leong, FSS

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[6] *Id.* at 4.
[7] CMS Ruling 1727-R at unnumbered page 9 (April 23, 2018) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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CERTIFIED MAIL

Toyon Associates, Inc.
Christine Ponce
Director - Client Services
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AUG 21 2018

RE: El Camino Hospital, Provider No. 05-0308, FYE 06/30/2010
PRRB Case No. 14-1744

Toyon FY 2010 Accuracy of CMS Developed SSI Ratio Issued 3/16/2012 Group
PRRB Case No. 14-3134G

Toyon 2010 Accuracy of CMS Developed SSI Ratio Group, PRRB Case No. 17-1639G

Dear Ms. Ponce:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeals in response to a request to transfer the Provider's SSI Accuracy issue to a group appeal. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

Toyon Associates, Inc. (Toyon) filed an individual appeal for El Camino Hospital on January 14, 2014 for which the Board established case number 14-1744.

On August 7, 2014, Toyon filed a Request to Transfer Issue to A Group Appeal (Model Form D) transferring the SSI Accuracy issue to the Toyon FY 2010 Accuracy of CMS Developed SSI Ratio Issued 3/16/2012 Group, case number 14-3134G. The group appeal was subsequently dismissed on February 15, 2017 for the Group's failure to timely file a final position paper.

In a letter dated June 16, 2017, Toyon indicated that all issues in case number 14-1744 had been transferred to group appeals or had been resolved. In response, the Board closed the individual case on June 26, 2017.

On August 7, 2018, Toyon submitted a Model Form D, requesting the transfer of the SSI Accuracy issue from the subject individual appeal to the Toyon 2010 Accuracy of CMS Developed SSI Ratio Group, case number 17-1639G. The cover letter attached to the Model Form D explained that, because the group to which it had previously transferred the issue had been dismissed, the Provider was now requesting to transfer the issue to a new SSI Accuracy group in order to preserve the Provider's appeal rights.

Board Determination:

The Board hereby denies the Provider's Request to Transfer the SSI Accuracy issue to the Toyon 2010 Accuracy of CMS Developed SSI Ratio Group, case number 17-1639G. Both the individual appeal and the group to which the Provider initially transferred the SSI Accuracy issue are in a closed status. Board Rule 4.7 states that once an issue is dismissed or withdrawn, the same issue may not be appealed in another case. Since the cases involved here have been dismissed or withdrawn, the Board will not permit the SSI Accuracy issue to be placed in another case.

A similar set of facts has been litigated in *Baptist Memorial Hospital-Golden Triangle v. Leavitt*.[1] In that case, the various Providers filed individual appeals and then transferred issues to group appeals. Subsequently, the group appeals were dismissed for failure to file preliminary position papers and the Providers did not seek reinstatement. The Providers then added the dismissed issues to their individual appeals and tried to create second group appeals of the issues involved in the original group appeals. The Board dismissed the second appeals stating that the "providers cannot now rely on adding the same issue again to their individual appeals to get a second opportunity to join the group."[2] The Court agreed, noting that "allowing Providers to simply re-file previously-dismissed claims directly undermines the time limits in the PRRB instructions."[3]

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

FOR THE BOARD:

Board Member

cc: Lorraine Frewert, Noridian Healthcare Solutions (J-E)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

[1] 536 F. Supp. 2d 25 (D.D.C. 2008), aff'd 566 Fed. 3d 266 (D.C. Cir. 2009).
[2] *Id. at 29-30.*
[3] *Id. at 35.*

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AUG 2 1 2018

RE: **Expedited Judicial Review Determination**

K&S 2007 DSH Medicare Advantage Days Group
Provider Nos. Various
FYE 2007
PRRB Case No. 18-1440G

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 9, 2018 requests for expedited judicial review (EJR) (received August 10, 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]

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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.

[18] *Id.*

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

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

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

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[21]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[22] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the 2004 rule that the Board lacks the authority to grant. The Providers maintain that, since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2017), the Board is required to grant an EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a

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[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.

specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Jurisdictional Determination

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

For 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]

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

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request involves the fiscal year 2007, thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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[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. § 405.1837.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

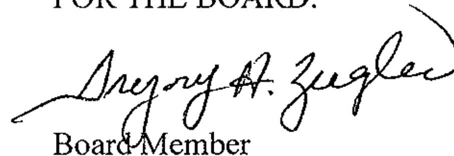
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

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

Board Members Participating:

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: Mounir Kamal, Novitas Solutions (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
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410-786-2671

Certified Mail

AUG 2 1 2018

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

RE: **Expedited Judicial Review Determination**

18-0974GC Bon Secours Charity Health System 2007, 2009 Medicare HMO Part C Days - Medicare Fraction CIRP Group
18-0975GC Bon Secours Charity Health System 2007, 2009 Medicare HMO Part C Days - Medicaid Fraction CIRP Group I
18-1116GC Bon Secours Charity Health System 2010-2012 Medicare HMO Part C Days - Medicare Fraction CIRP Group
18-1117GC Bon Secours Charity Health System 2010, 2012 Medicare HMO Part C Days - Medicaid Fraction CIRP Group

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's August 8, 2018 request for expedited judicial review (EJR) (received August 10, 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]

[1] Providers' EJR request at 1.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

> including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

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

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

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

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

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

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[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*
[14] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[17] 69 Fed. Reg. at 49,099.

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

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

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

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

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

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.

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

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 in this EJR request have filed an appeals involving fiscal years 2007-2012.

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]

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[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.

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 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 2007-2012 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.C. 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;

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[26] *See* 42 C.F.R. § 405.1837.

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

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

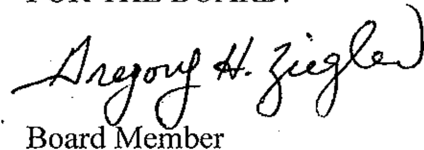
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' 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
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Baltimore, MD 21207
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CERTIFIED MAIL

AUG 2 7 2018

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

RE: Jurisdictional Decision
University of New Mexico 2017 DSH Uncompensated Care Payment CIRP Group
PRRB Case No. 17-0896GC

Dear Ms. Webster,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the jurisdictional documents in case number 17-0896GC and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The Providers filed this group appeal request from the Final Rule issued in the Federal Register issued on August 22, 2016: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2017 Rates.[1]

The Providers are challenging the procedural and substantive validity of the Secretary's determination of their disproportionate share hospital ("DSH") payment amounts for uncompensated care costs for Federal Fiscal Year 2017. The Providers contend that the Secretary's determinations and rule are arbitrary, capricious, reflect an abuse of discretion, are not based upon substantial evidence, violate the notice and comment rulemaking requirements and are otherwise contrary to law.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[2]

[1] 81 Fed. Reg. 56762 (Aug. 22, 2018).

[2] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[3] upheld the D.C. District Court's decision[4] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General,* the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[5] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[6]

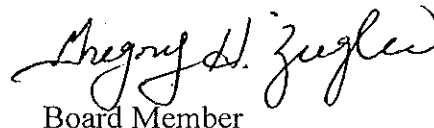
The Board finds that the same findings are applicable to the Providers' challenge to their 2017 uncompensated care payments. As in *Tampa General,* the Providers here are challenging the calculation of the amount they received for uncompensated care for FY 2017. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in PRRB Case No. 17-0896GC because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes PRRB Case No. 17-0896GC and removes the appeal from its 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
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A
Robert Evarts, Esq.

FOR THE BOARD



Board Member

[3] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[3]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[4] 89 F. Supp. 3d 121 (D.D.C. 2015).
[5] 830 F.3d 515, 517.
[6] *Id.* at 519.

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

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AUG 2 8 2018

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RE: **Expedited Judicial Review Determination**

CHS 2006 DSH Medicare + Choice Days Group, PRRB Case No. 13-0421GC

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 13, 2018 request for expedited judicial review (EJR) (received August 14, 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]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> *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.

<u>Providers' Requests 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). In these cases, the Providers contend that all

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

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 2006.

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 all of the Providers in this appeal filed their appeals from revised NPRs and that the revised NPR appeals included within this EJR request were issued after August 21, 2008. The Providers listed below appealed revised NPRs that did not adjust Part C days in either the Medicaid fraction or SSI percentage, and the subject of the revised NPR was not the matter under appeal as required for Board jurisdiction under 42 C.F.R. § 405.1889(b)(1). The Board hereby finds that it lacks jurisdiction over the Providers listed below and hereby dismisses the following Providers from the appeal:

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

#17 Gateway Medical Center, provider number 44-0035
#18 Wesley Medical Center, provider number 25-0044

Since jurisdiction over a provider is a prerequisite for granting a request for EJR, the request for EJR for #17 Gateway Medical Center and #18 Wesley Medical Center is hereby denied.

The Board has determined that the remaining participants involved with the instant EJR request have had a specific adjustment to the SSI fraction, 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 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.C. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.[27]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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[26] *See* 42 C.F.R. § 405.1837.

[27] 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.

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

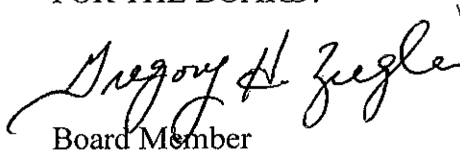
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

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 the 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, WPS (Certified Mail w/Schedule of Providers)
Wilson Leong, Esq., Federal Specialized Services (w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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AUG 29 2018

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RE: **Expedited Judicial Review Determination**

18-0186GC	Scripps Health 2006-2007 Medicare HMO Part C Days - Medicaid Fraction CIRP Group
18-0187GC	Scripps Health 2006-2007 Medicare HMO Part C Days - Medicare Fraction CIRP Group
18-0319GC	Scripps Health 2008-2009 Medicare HMO Part C - Medicare Fraction CIRP Group
18-0327GC	Scripps Health 2008-2009 Medicare HMO Part C Days - Medicaid Fraction CIRP Group
18-0331GC	Scripps Health 2010-2011 Medicare HMO Part C Days - Medicare Fraction CIRP Group
18-0332GC	Scripps Health 2010-2011 Medicare HMO Part C Days - Medicaid Fraction CIRP Group
18-0370GC	Scripps Health 2012-2013 Medicare HMO Part C Days - Medicaid Fraction CIRP Group
18-0371GC	Scripps Health 2012-2013 Medicare HMO Part C Days - Medicare Fraction CIRP Group

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's August 6, 2018 request for expedited judicial review (EJR) (received August 7, 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]

[1] Providers' EJR request at 1.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

> including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

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

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

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

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

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

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[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*
[14] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[17] 69 Fed. Reg. at 49,099.

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

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

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

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

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

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.

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

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 in this EJR request have filed an appeals involving fiscal years 2006-2013.

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]

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[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.

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 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 2006-2013 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;

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[26] *See* 42 C.F.R. § 405.1837.

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' 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: Lorraine Frewert, Noridan Healthcare Solutions (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
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410-786-2671

AUG 3 0 2018

Electronic Delivery

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

RE: **Expedited Judicial Review Determination**

15-2776GC CHI 2013 DSH Medicaid Fraction Part C Days Group
15-2778GC CHI 2013 DSH SSI Fraction Part C Days Group
16-0107GC SWC McLeod Health 2011-2012 DSH SSI Fraction Part C Days Group
16-0108GC SWC McLeod Health 2012 DSH Medicaid Fraction Part C Days Group
17-1750G Southwest Consulting 2012 DSH SSI Fraction Part C Days Group III

Dear Mr. Newell:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 14, 2018 request for expedited judicial review (EJR) (received August 17, 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

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[1] Providers' EJR Request at 4.
[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).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<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).

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

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

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 2011-2013.

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

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[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. 30,190, 30,240 (May 23, 2008).
[26] 201 F. Supp. 3d 131 (D.D.C. 2016)
[27] *Banner* at 142.

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

The Board has determined that the participants involved with the instant EJR request 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 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 involves the fiscal years 2011-2013, 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.C. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

1) it has jurisdiction over the matter for the subject years and that the 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

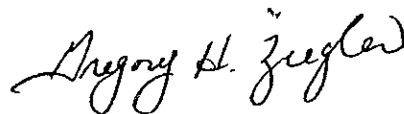
4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

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

Board Members Participating:

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

FOR THE BOARD:



Board Member

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

cc: Bruce Synder, Novitas (Electronic delivery w/Schedule of Providers)
Laurie Polson, Palmetto GBA c/o NGS (Electronic delivery w/Schedule of Providers)
Wilson Leong, FSS (Electronic delivery 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

AUG 31 2018

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

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

RE: Jurisdictional Decision
Provider: Wuesthoff Medical Center - Melbourne
Case Number: 17-1919
FYE: 09/30/2014

Dear Mr. Summar and Mr. Pike:

Wuesthoff Medical Center - Melbourne (the "Provider) has appealed an original Notice of Program Reimbursement (NPR) dated February 1, 2017 which addresses its fiscal year end (FYE) September 30, 2014 cost reporting period. The Provider filed a Model Form A – Individual Appeal Request (July 19, 2017) which contained eleven issues.

The Medicare Contractor has filed a Jurisdictional Challenge (May 18, 2018) regarding the last remaining issue in the appeal: Issue No. 7 addressing "Disproportionate Share Hospital Payment – Medicaid Eligible Days" (hereinafter "DSH Medicaid Eligible Days"). *See* Provider's Model Form A – Individual Appeal Request (July 19, 2017), Tab 3 at unnumbered page 7. The Provider filed a Jurisdictional Response (July 3, 2018).

Medicare Contractor's Position

The Medicare Contractor contends the Board does not have jurisdiction over the DSH Medicaid Eligible Days issue in this appeal because the days were neither claimed nor self-disallowed as required by 42 C.F.R. 405.1835(a)(1). The Medicare Contractor explains that it made no final determination regarding the disputed days and the Provider did not protest this item on its cost

report. Additionally, the Medicare Contractor claims that any reliance by the Provider on *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016) is misplaced because in the instant appeal the Provider is not challenging a regulation or statute.

The Provider's Position

The Provider contends an audit adjustment is not required for Board jurisdiction, and also argues audit adjustment nos. 14 and 16 adjusted the DSH payment which warrants Board jurisdiction over this issue. The Provider claims it is not required to express dissatisfaction with a specific cost item, but rather can meet the dissatisfaction requirement by being dissatisfied with the amount of total reimbursement. The Provider states the presentment requirement as well as the "practical impediment" requirement are not valid and do not apply in this situation.

The Provider claims the self disallowance requirement of 42 C.F.R § 405.1811(a)(1)(ii) does not apply because the Provider had a good faith belief that claiming reimbursement for the DSH Medicaid Eligible Days it now seeks would have been futile because these days were 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. The Provider states this issue comes within CMS Ruling 1727-R.

Board Decision

The Board finds that it has jurisdiction over the DSH Medicaid Eligible Days issue in this appeal.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2016), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

At issue in this jurisdictional dispute is the dissatisfaction requirement for Board jurisdiction. Regulation dictates that a provider must preserve its right to claim dissatisfaction with the amount of Medicare payment for the specific items at issue, by either –

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

42 C.F.R. 405.1835(a)(1)(2013).

However, *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016) ("*Banner*") holds that a provider cannot be held to the claim preservation/presentment requirement of 42 C.F.R. § 405.1835(a)(1) when the provider is challenging a Medicare regulation or policy which the Medicare contractor has no authority to entertain or decide (such as a challenge to a Medicare regulation or policy). The *Banner* court explained its decision as

> …when a provider fails to present a claim in its cost report that [a Medicare contractor] can address, it can be deemed "satisfied" with the amounts requested in the cost report and awarded by the [Medicare contractor]. But where the [Medicare contractor] has no authority to address a claim, such as when a pure legal challenge to a regulation is at issue, a provider cannot be deemed to be "satisfied" simply because such challenge is not reflected in the cost report. Satisfaction cannot be imputed from a provider's silence when everyone knows that it would be futile to present such claim to the [Medicare contractor].

Banner at 141.

The *Banner* court looked to *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) ("*Bethesda")* which also addressed a challenge to a regulation which was not first presented to the Medicare contractor. *Bethesda* holds that a provider need not protest self-disallowed costs that are barred from being claimed because of a specific statute, regulation, or ruling. *Id.* at 404. The Supreme Court in *Bethesda* stated:

> . . . [T]he submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the [Contractor]. Providers know that, under the statutory scheme, the [Contractor] is confined to the mere application of the Secretary's regulations, that the [Contractor] is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the [Contractor] to do otherwise would be futile.

Bethesda at 404.

CMS recently issued Ruling CMS-1727-R ("Ruling 1727") to state its policy to follow the holding in *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016). Ruling 1727 sets out a five-step analysis for the Board to undertake to determine whether a provider is entitled to a hearing for an item that the provider appealed but did not include on its cost report. In short, a provider has a right to a Board hearing for a cost item if it excluded the item based upon "a good faith belief that the item was subject to a payment regulation or other policy that gave the Medicare contractor no authority or discretion to make payment in the manner the provider sought." Ruling 1727 at unnumbered page 2.

Analysis of the DSH Medicaid Eligible Days Under Ruling 1727

The first step of analysis under Ruling 1727 involves the appeal's filing date and cost reporting period. The appeal must have been pending or filed after the Ruling was issued on April 23, 2018. In the instant case, the Board received the Provider's request for hearing on July 26, 2017 and the appeal was open on April 23, 2018, thus it satisfies the appeal pending date requirement. Additionally, the Ruling applies to appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016. This appeal involves a fiscal year end September 30, 2014 cost report, thus the appealed cost reporting period falls within the required time frame.

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." Ruling 1727 at 6.

Under Sections 1815(a) and 1833(e) of the Social Security Act, Medicare payments are not 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 DSH 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 claimed…and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." 42 C.F.R. § 412.106(b)(4)(iii) (2010).

In the instant appeal, the Provider argues it "had a good faith belief that claiming reimbursement for the additional DSH Eligible Days in the cost report would be futile because doing [so] was subject to a regulation or other payment policy that bound the MAC and left the MAC with no authority or discretion to make payment in the manner sought by the Provider." *See* Jurisdictional Response (July 3, 2018) at 11. The Provider also explains "the Provider was prohibited from claiming the additional Medicaid Eligible Days in the cost report because the State matching data had not been issued as of the deadline for filing the cost report." *Id.* Because these DSH Medicaid eligible days were not included in the Medicaid fraction, the Provider claims that the Medicare contractor's DSH Medicaid fraction calculation is incorrect. *See* Model Form A – Individual Appeal Request (July 19, 2017), Tab 3 at unnumbered page 7.

As the pertinent DSH regulations require a provider submit proof of Medicaid eligibility along with State verification 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 the Provider's DSH Medicaid Eligible Days 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, this issue meets the second requirement or step of Ruling 1727.

The third, fourth and fifth steps of analysis under Ruling 1727 involve the Board's assessment of whether a provider's appeal has met the jurisdictional requirements set out in 42 C.F.R. § 405.1835. As the Provider's appeal was timely filed and the estimated amount in controversy is over $10,000, the first two Board jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, Ruling 1727 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, the DSH Medicaid Eligible Days sought are <u>not</u> within the payment authority or discretion of the Medicare Contractor because Provider could not prove or verify eligibility with the State in time to include the Days on the Provider's cost report, as required by regulation.

Under step four of Ruling 1727, the Board does not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable) if a determination has been made that the item under appeal was subject to a regulation or other policy that bound the Medicare Contractor and left it with no authority or discretion to make payment as sought. As discussed in step two above, these DSH Medicaid Eligible Days are "non-allowable" costs because the Medicare Contractor was bound by the proof of eligibility and verification regulation at 42 C.F.R. § 412.106(b)(4)(iii), and therefore the Board will "not apply the self-disallowance jurisdiction regulation" in this jurisdictional decision.

Under step five of Ruling 1727, the Board is directed to consider the circumstances surrounding a provider's self-disallowance claim. In the instant appeal, however, the Provider did not self-disallow the DSH Medicaid Eligible Days issue, thus this step is not applicable to this appeal.

The Board finds that Wuesthoff Medical Center - Melbourne's DSH Medicaid Eligible Days issue is within the Board's jurisdiction, based upon the *Banner* rationale and Ruling 1727-R, as it would have been futile to present DSH Medicaid Eligible Days to the Medicare Contractor without proof of eligibility and State verification. However, the Board directs that only those DSH Medicaid Eligible Days which were not able to be verified prior to the cost report filing date are subject to the Board's jurisdiction under *Banner* and Ruling 1727-R, and that the

Provider and the Medicare Contractor shall, based on information privy to these two parties, ascertain the DSH Medicaid Eligible Days that are subject to the Board's jurisdiction.

In conclusion, the Board finds it has jurisdiction over the DSH Medicaid Eligible Days issue, and the appeal remains open for resolution of this issue. Review of this decision may be available under 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members

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

FOR THE BOARD

Board Member

cc: Wilson Leong, Esq., FSS