DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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MAR 01 2018

Certified Mail

Corinna Goron
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RE: **EJR Determination**
HRS 2008 DSH Medicare Fraction Medicare Managed Care Part C Days Group, PRRB Case No. 13-3619G
HRS 2009 SSI Fraction Medicaid Managed Care Part C Days Group, PRRB Case No. 14-0714G

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 10, 2018 request for expedited judicial review (EJR)[1] (received January 12, 2018) and the Providers' February 14, 2018 response to the Board's February 2, 2018 request for additional information (received February 16, 2018). The Board's decision with respect to jurisdiction and EJR is set forth below.

Issue in Dispute

The issue in dispute in these cases is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] The EJR request included appeals for case numbers 15-2457G, 15-3344G and 15-3342G. In separate correspondence, the Board granted the Providers' request for EJR in correspondence dated February 2, 2018.
[2] *See generally* Providers' hearing request Tab 3.

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

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

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

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

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

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

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

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

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

> *part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period. (emphasis added)

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,[21] vacated the FFY 2005 IPPS rule. However, the Secretary has not acquiesced to that decision.[22] More recently in *Allina Health Services v.* Price *(Allina II)*,[23] the Court found that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction was vacated by *Allina Health Services* above. The Court found that the Secretary was required to undertake notice and comment ruling-making and the 2012 regulation was invalid. Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

The Providers explain that because the Secretary has not acquiesced to the decision in *Allina,* the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (the 2004 Rule). The Board is bound by the 2004 rule and the Providers and the Providers contend that the Board should grant their request for EJR.

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

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[19] *Id.*
[20] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] Providers' EJR request at 1.
[23] 2017 WL 3137976 (D.C. Cir. July 25, 2017).

Decision of the Board

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

Jurisdictional Determination

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

For appeals of original NPRs for cost reporting periods ending before December 31, 2008, the providers may demonstrate dissatisfaction with the amount of Medicare reimbursement of the Part C days issue by claiming the issue as a "self-disallowed cost" pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[24]

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

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

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[24] 485 U.S. at 399 (1988). Under the facts of *Bethesda*, the Board initially found that it was without jurisdiction to review the providers' challenge to the Secretary's regulation regarding apportionment of malpractice insurance costs because the providers had "self-disallowed" the costs in their respective cost reports filed with the Medicare contractor. The Supreme Court held that "[t]he Board may not decline to consider a provider's challenge to a regulation of the Secretary on the ground that the provider failed to contest the regulation's validity in the cost report submitted to [the Medicare Contractor]." The Court went on to state that "the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations."

[25] 42 C.F.R. § 405.1835(a)(1) (2008).

[26] *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

cc: Lorraine Frewert, Noridian Healthcare Solutions (Certified Mail w/Schedules of Providers)
Wilson Leong, FSS (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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MAR 01 2018

Certified Mail

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RE: HLB FY 2009 DSH Medicare Part C Days/SSI Fraction Group
Provider Nos. Various
FYE 2009
PRRB Case No. 18-0847G

Dear Mr. Roth:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 14, 2018 request for expedited judicial review (EJR) (received February 15, 2018) for the above-referenced appeal. The Board's determination is set forth below.

Issue in Dispute

The issue in dispute in this appeal is:

> W]hether the Hospitals' FY [Federal Year] 2009 DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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[1] Providers' February 14, 2018 EJR Request at 2.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Providers' Request for EJR

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

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal[22] because the providers' appeals were timely filed and the $50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the 2004 rule [codified in the 2005 regulation at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B)].[23]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2017), the Board is required to grant an EJR request if it determines that (i) the Board has jurisdiction to

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] Providers' EJR request at 2.
[22] *See* 42 C.F.R. § 405.1837.
[23] *See* 42 C.F.R. § 405.1842(f)(1).

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

Jurisdictional Determination

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

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost reports for the period where the providers seek payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing cost reports under protest.[24]

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

Board's Analysis Regarding the Appealed Issue

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

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[24] 42 C.F.R. § 405.1835(a)(1) (2008).
[25] *See* 42 C.F.R. § 405.1837.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

MAR 01 2018

Certified Mail

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Washington, D.C. 20004

RE: HLB FY 2012 DSH Medicare Part C Days/SSI Fraction Group
Provider Nos. Various
FYE 2012
PRRB Case No. 18-0912G

Dear Mr. Roth:

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

Issue in Dispute

The issue in dispute in this appeal is:

> W]hether the Hospitals' FY [Federal Year] 2012 DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

[1] Providers' February 16, 2018 EJR Request at 2.
[2] *See* 42 U.S.C. § 1395ww(d)(I)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Providers' Request for EJR

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

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal[22] because the providers' appeals were timely filed and the $50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the 2004 rule [codified in the 2005 regulation at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B)].[23]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2017), the Board is required to grant an EJR request if it determines that (i) the Board has jurisdiction to

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] Providers' EJR request at 2.
[22] *See* 42 C.F.R. § 405.1837.
[23] *See* 42 C.F.R. § 405.1842(f)(1).

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

Jurisdictional Determination

The participants that comprise the group appeal within this EJR request have filed appeals involving fiscal year 2012.

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost reports for the period where the providers seek payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing cost reports under protest.[24]

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

Board's Analysis Regarding the Appealed Issue

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

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[24] 42 C.F.R. § 405.1835(a)(1) (2008).
[25] *See* 42 C.F.R. § 405.1837.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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MAR 01 2018

Certified Mail

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401 9th Street, NW
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Washington, D.C. 20004

RE: HLB FY 2011 DSH Medicare Part C Days/SSI Fraction Group
Provider Nos. Various
FYE 2009
PRRB Case No. 18-0911G

Dear Mr. Roth:

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

Issue in Dispute

The issue in dispute in this appeal is:

> W]hether the Hospitals' FY [Federal Year] 2011 DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

[1] Providers' February 16, 2018 EJR Request at 2.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Providers' Request for EJR

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

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal[22] because the providers' appeals were timely filed and the $50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the 2004 rule [codified in the 2005 regulation at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B)].[23]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2017), the Board is required to grant an EJR request if it determines that (i) the Board has jurisdiction to

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] Providers' EJR request at 2.
[22] *See* 42 C.F.R. § 405.1837.
[23] *See* 42 C.F.R. § 405.1842(f)(1).

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

Jurisdictional Determination

The participants that comprise the group appeal within this EJR request have filed appeals involving fiscal year 2011.

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost reports for the period where the providers seek payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing cost reports under protest.[24]

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

Board's Analysis Regarding the Appealed Issue

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

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[24] 42 C.F.R. § 405.1835(a)(1) (2008).
[25] *See* 42 C.F.R. § 405.1837.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

MAR 01 2018

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

RE: HRS FMOLHS 2006 SSI Fraction Medicare Managed Care Part C Days CIRP Group
PRRB Case No. 16-1440GC

HRS FMOLHS 2006 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group
PRRB Case No. 16-1442GC

Specifically: Our Lady of the Lake Regional Medical Center (19-0064), FYE 06/30/2006

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has reviewed your February 15, 2018 Schedules of Providers in the above-captioned appeals which you submitted in relation to a request for expedited judicial review (EJR) on February 26, 2018. The Board notes that each group contains only one participating provider.

Pursuant to 42 C.F.R. § 405.1837(b), "[T]wo or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue . . . must bring the appeal as a group. Although a common issue related party (CIRP) group may be formed with a single provider, the group must have at least two participants upon full formation.[1]

Upon review, the Board finds that there is not a pending individual appeal for this Provider for the 2006 FYE to which the SSI Fraction Managed Care Part C Days and Medicaid Fraction Managed Care Part C Days issues can be transferred. The Provider has a combined estimated reimbursement impact of over $600,000, which is well over the minimum threshold required for an individual appeal. Therefore, the Board is electing to convert Case No. 16-1440GC to an individual appeal for Our Lady of the Lake Regional Medical Center for FYE 2006. The new case which will now be called Our Lady of the Lake Regional Medical Center (Case No. 16-1440) will include both the SSI Fraction and Medicaid Fraction Managed Care Part C Days issues. As there are no remaining participants/issues in Case No. 16-1442GC, the case is hereby closed.

Please reference Case No. **16-1440** in future correspondence regarding Our Lady of the Lake Regional Medical Center's FYE 2006 appeal. The Board's determination on the request for EJR will be issued under this individual case number under separate cover once the Board has reviewed the other jurisdictional elements.

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

For the Board:

L. Sue Andersen, Esq.
Chairperson

cc: Mounir Kamal, Novitas Solutions, Inc. (J-H)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

[1] Board Rule 12.5 (Issued Aug.21, 2008; Revised July 1, 2009; March 1, 2013; July 1, 2015.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
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MAR 01 2018

PRRB Case No. 12-0559GC

CERTIFIED MAIL

Robert L. Roth
Hooper, Lundy & Bookman, P.C.
401 9th Street, N.W.
Suite 550
Washington, DC 20004

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

Re: PRRB Case No. 12-0559GC
Expedited Judicial Review
Group: HCA FFY 2006 Outlier Threshold Group
FYE: 09/30/2006

Dear Mr. Roth and Mr. Lamprecht:

The Provider Reimbursement Review Board ("Board" or "PRRB") reviewed the Group's February 2, 2018 Expedited Judicial Review ("EJR") Request. The Board determined that it has jurisdiction over all of the providers in the Group. The Board finds that the Outlier Threshold issue appealed by the Group is appropriate for EJR and hereby grants the Group's request. This EJR closes Case No. 12-0559GC. The Board's determination is outlined below.

Background

The group appeal presents the claim that the hospitals received insufficient outlier payments for discharges that occurred during the portions of their fiscal years that came within Federal Fiscal Year ("FFY") 2006, and challenges the methodology (including data) that the Secretary used to calculate these outlier payments.[1] More specifically, the hospitals are challenging the outlier payment methodology, including the "outlier threshold" that the Secretary adopted in FFY 2006 IPPS Final Rule (70 Fed. Reg. 47278, 47493-96 (Aug. 12, 2005)).[2] 42 U.S.C. § 1395ww(d)(5)(A) (emphasis added) provides:

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

[1] Group's Request for EJR ("EJR Request") at 1, Feb. 2, 2018.
[2] EJR Request at 2.

> shall . . . approximate the marginal cost of care beyond the cutoff point applicable under clause . . . (ii).[3]

The "fixed dollar amount" represents the outlier threshold. The Group states:

> By statute, total outlier payments for a federal fiscal year can "not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year." 42 U.S.C. § 1395ww(d)(5)(A)(iv). The Secretary implements this requirement by setting the outlier threshold generally (and for FFY 2006) so that predicted outlier payments would equal 5.1% of predicted total DRG payments. *See* 70 Fed. Reg. at 47495. To pay for outliers, the Secretary is required to make a corresponding 5.1% cut to the national base payment rate (the "standardized amount") for each patient discharge. 42 U.S.C. § 1395ww(d)(3)(B). Thus, Congress requires the Secretary to design the annual outlier threshold so that the 5.1% cut in the standard DRG payments goes back to the hospitals in the form of outlier payments.[4]

The Group contends that, for FFY 2006, the Secretary's outlier methodology and data caused the outlier threshold to be set too high, which caused all of the outlier payments made during FFY 2006 to be too low.[5] Therefore, the Group argues, the Secretary failed to pay out the total amount of the outlier "pool" created by a reduction in standardized payments, and otherwise acted unlawfully.[6] The Group states that, in the FFY 2007 IPPS Final Rule, the Secretary indicated that the target was not met, stating that outlier payments were only 4.62% of total DRG payments in FFY 2006.[7] Thus, the Group contends that there is no factual dispute as to whether the Secretary met the target percentage.[8]

The hospitals also challenge the Secretary's actions as arbitrary and capricious. The Group contends that the Secretary failed to take into account the comments submitted during the rulemaking process and instead continued an "imperfect process," when a more accurate method should and could have been used.[9] The Group states that the Board does not have the authority to rule on this issue because it is bound by the regulations and cannot set aside the outlier threshold established by the Secretary.[10] The Group requests that the Board grant EJR for this issue.

Board Determination

The regulation governing EJR states:

> (a)(1) This section implements provisions in section 1878(f)(1) of the Act that give a provider the right to seek EJR of a legal

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[3] *Id.* (citing 42 U.S.C. § 1395ww(d)(5)(A)(ii) and (iii)).
[4] EJR Request at 2.
[5] *Id.* at 3.
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] *Id.* at 5.

> question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
>
> . . .
>
> (f)(1) The Board's decision must grant EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines the following conditions are satisfied:
>
> (i) The Board has jurisdiction to conduct a hearing on the specific matter at issue . . .
>
> (ii) The Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[11]

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

Jurisdiction

In order to have a right to a Board hearing, the providers in the group must be dissatisfied with their final determinations of the total amount of reimbursement due the providers; the amount in controversy must be at least $50,000; the date of receipt by the Board of the providers' hearing request must be no later than 180 days after the date of receipt of the providers' final determinations; and, the matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group.[12] The Schedule of Providers shows that each of the hospitals timely appealed.[13] The estimated reimbursement amount for the 296 providers involved is $10,160,721.00.[14] Further, as the FYE is prior to the 12/31/08 regulation changes, *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) applies, allowing the providers to "self-disallow" the outlier fixed loss threshold, as they would not have an audit adjustment on their cost reports. All of the providers appealed from original NPRs. Therefore, the Board finds that it has jurisdiction over all of the providers pursuant to *Bethesda Hosp. Ass'n v. Bowen*.

Legal Authority

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit EJR if the Board determines that it does not have the authority to decide a question of law, regulation, or CMS Ruling. In this case, the Group challenges the validity of the Secretary's outlier determination under 42 U.S.C. §§ 1395ww(d)(3)(B) and (d)(5)(A) (outlier statutes); 42 C.F.R. §§ 412.8(b), 412.80(c); and, 70 Fed. Reg. 47278 (Aug. 12, 2005). The Group states that the Board lacks

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[11] 42 C.F.R. § 405.1842.

[12] 42 C.F.R. § 405.1837.

[13] Schedule of Providers, Jan. 28, 2018.

[14] *Id.*

the authority to set aside the outlier threshold or aspects of the outlier methodology because they were published in regulatory form by the Secretary.[15] The Group mentions that the Board issued EJR in an earlier, similar case (Case No. 11-0057GC) for FFY 2004.[16] Therefore, the Group believes EJR is appropriate and requests the Board to grant EJR.

The Board finds that the outlier issue properly falls within the provisions of 42 C.F.R. § 405.1842 since it is a challenge to the substantive validity of the Secretary's application of the outlier statutes and regulations. The Board lacks the authority to determine whether the Secretary's outlier threshold was valid. The Board agrees with the Group that it lacks legal authority in this case. The Board finds that:

(1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board except as otherwise noted above;
(2) Based upon the Providers' assertions regarding 42 U.S.C. §§ 1395ww(d)(3)(B) and (d)(5)(A); 42 C.F.R. §§ 412.8(b), 412.80(c); and, 69 Fed. Reg. 48915, 49275-78 (Aug. 11, 2004), there are no findings of fact for resolution by the Board;
(3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and,
(4) It is without the authority to decide the legal question of whether the Secretary's fixed loss threshold for outlier payments is valid.

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

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

Enclosure: Schedule of Providers

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

[15] EJR Request at 5.
[16] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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CERTIFIED MAIL

MAR 01 2018

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

RE: Springs Memorial Hospital
Provider No. 42-0036
FYE 11/30/2014
PRRB Case No. 17-1744

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed correspondence from you, dated February 7, 2018 (received by the Board on February 20, 2018). The correspondence, which is a copy of a cover letter addressed to the Medicare Contractor, transmits the Provider's preliminary position paper. In addition, it advises that all issues, except Medicaid Eligible Days and SSI Provider Specific, have been transferred to group appeals.

Upon review the Board notes that this case was dismissed by the Board on July 18, 2017 because the appeal was not filed in conformance with 42 C.F.R. § 405.1835 and the Board Rules as it did not include a copy of the final determination in dispute. If you disagree with the Board's dismissal, you may request a reinstatement of the appeal under Rule 46 of the PRRB rules. PRRB Rule 46.1, in part, states:

> A Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the Provider's withdrawal of the issue(s) (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions).

With regard to your statement, that all issues have been transferred to groups with the exception of Medicaid Eligible Days and SSI Provider Specific, the Board has no record of any transfer requests for the other issues that were appealed in this case. Because the case is in a closed status, any request to transfer an issue to a group appeal would be denied by the Board.

Board Members:
L. Sue Andersen, Esq.
Charlotte F. Benson, C.P.A.
Gregory H. Ziegler

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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MAR 01 2018

CERTIFIED MAIL

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

Noridian Healthcare Solutions, LLC
John Bloom
Appeals Coordinator
JF Provider Audit Appeals
P.O. Box 6722
Fargo, ND 58108-6722

RE: Jurisdiction Decision
St. Alexius Medical Center
Provider. No. 35-0002
FYE 6/30/2009
PRRB Case No. 14-1127

Dear Mr. Ravindran and Mr. Bloom,

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

Background

On May 31, 2013, the Provider, St. Alexius Medical Center, was issued an original Notice of Program Reimbursement ("NPR") for fiscal year end ("FYE") 6/30/2009. The Provider filed its appeal request with the Board on November 29, 2013, in which it appealed 8 issues, including the Medicaid eligible days issue.

The Medicare Contractor filed a jurisdictional challenge with the Board on January 8, 2015, over two issues: Medicaid Eligible Days and Rural Floor Budget Neutrality Adjustment ("RFBNA"). The Provider has since withdrawn the RFBNA issue, therefore the Board will not address that portion of the jurisdictional challenge. The Provider responded to the jurisdictional challenge on February 4, 2015.

Medicare Contractor's Contentions

The Medicare Contractor argues that the Board does not have jurisdiction over the Medicaid Eligible Days issue because the Provider did not include a claim for the specific item on its cost

report, nor did it self-disallow the days by protesting them on the cost report. The Medicare Contractor concludes that the Provider did not preserve its right to claim dissatisfaction with those days in accordance with 42 C.F.R. § 405.1835(a).

Provider's Contentions

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

Board's Decision

The Provider is appealing from a 6/30/2009 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider **has preserved its right to claim dissatisfaction . . . by . . . [i]ncluding a claim for specific item(s) on its cost report...or...self-disallowing the specific item(s) by . . . filing a cost report under protest.**[2]

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

Conclusion

The only issue pending in the appeal is the Medicaid Eligible Days issue. The Board finds that it does not have jurisdiction over the Medicaid Eligible Days issue because the Provider did not claim or protest the days on its 6/30/2009 cost report and dismisses the issue from this appeal.

As no issues remain pending in the appeal, PRRB Case No. 14-1127 is hereby closed and removed from the Board's docket.

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

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[1] Provider's Jurisdictional Response at 4.
[2] 42 C.F.R. § 405.1835(a).

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

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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MAR 01 2018

CERTIFIED MAIL

Hall, Render, Killian, Heath & Lyman
Daniel F. Miller, Esq.
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National Government Services
Danene Hartley
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Jurisdiction Decision
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 jurisdiction documents in the above-referenced appeal. 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] The email also stated that the Provider should request those days in a reopening. On November 18, 2010, the Provider submitted a listing of days to the Medicare Contractor for review and incorporation in the final settlement.[3] The Medicare Contractor returned that listing to the Provider on October 25, 2011, and referred to its May 2010 email that it could not review anything else, and that the Provider should request a reopening.[4]

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

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

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.

On October 18, 2013, the Provider again submitted a listing of Medicaid eligible days to the Medicare Contractor and asked to resolve the appeal. The Medicare Contractor audited the Medicaid days as part of the resolution of the appeal and submitted a draft Administrative Resolution ("A/R") allowing an additional 2503 days.

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.

Medicare Contractor's Contentions

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

On November 18, 2010, the Provider attempted to amend its cost report filing to revise the operating and capital DSH reimbursement to include even more additional Medicaid paid and unpaid eligible days. The Medicare Contractor indicates that it returned the documentation to the Provider because a full review of the DSH was completed during audit, and indicated that the Provider should file a reopening request, which it did not do for eligible days.[5]

The Medicare Contractor concludes that there is no final determination over the additional Medicaid paid and unpaid eligible days, therefore the Board should find that it does not have jurisdiction.

Provider's Contentions:

According to the Provider, its NPR includes an adjustment to Medicaid eligible days from 5,888 to 5,329. The Provider argues that the Medicare Contractor's issuance of an "erroneous" adjustment, coupled with its failure to adhere to CMS regulatory and Program guidance, refutes the Medicare Contractor's jurisdictional challenge under the holding of *Bethesda Hospital Assoc. V. Bowen*, 485 U.S. 399 (1988) and *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016). The Provider also argues that it faced practical impediments in obtaining verified Medicaid eligibility data.

The Provider submitted its cost report for 12/31/2008 on June 18, 2009, and included 5,888 Medicaid eligible patient days, which the Medicare Contractor accepted.[6] In the spring of 2010, the Provider supplemented its filing with State-verified listings of Medicaid eligible days and requested a revision to the days reported. This submission included Wisconsin State verified data for 588 Wisconsin Medicaid HMO DSH days, which the Provider states were claimed on its

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[5] Medicare Contractor's Jurisdictional Challenge at 3.
[6] Provider's Response to Jurisdictional Challenge at 5.

as-filed cost report.[7] The Medicare Contractor responded that it was not able to review the revised listing and disallowed the 588 days and indicated that the Provider should request the 588 days as a reopening after the NPR is issued. In November 2010, the Provider submitted additional updated documentation for verified Minnesota and Wisconsin paid Medicaid lists and updated eligible but unpaid days.[8]

The Medicare Contractor and Provider agree that no objection has been raised to the 588 Medicaid HMO DSH Days. The dispute arises with regard to the State-verified Medicaid eligible days that the Provider initially submitted to the Medicare Contractor in November 2010. The parties were in the process of completing an Administrative Resolution when the Medicare Contractor filed this jurisdictional challenge.[9]

Board's Decision

The Provider is appealing from a 12/31/2008 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction. Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider **has preserved its right to claim dissatisfaction . . . by . . . [i]ncluding a claim for specific item(s) on its cost report...or...self-disallowing the specific item(s) by . . . filing a cost report under protest.**[10]

The Board finds that it does not have jurisdiction over the additional Medicaid eligible days that are the subject of this appeal. Because the Provider appealed from a 12/31/2011 cost report, it was required to either claim the days or protest them, and it did neither. Therefore, the Board concludes that it does not have jurisdiction and dismisses the Medicaid eligible days issue from this appeal.

As the Medicaid eligible days was the only issue pending in the appeal, PRRB Case No. 13-3675 is hereby closed and removed from the Board's docket.

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

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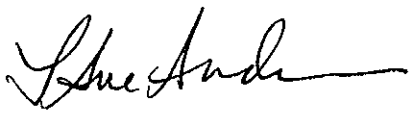
[7] *Id.*
[8] *Id.* at 6.
[9] *Id.* at 8.
[10] 42 C.F.R. § 405.1835(a).

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

FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

MAR 02 2018

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

PRRB Case Nos. 15-3400GC; 16-0244GC; 17-0507G; 17-2332G; 17-1929G; 18-0081GC; 16-1459G; 16-2096GC; 17-1751G; 17-0536GC; 17-0558GC

CERTIFIED MAIL

Stephen P. Nash
Squire Patton Boggs (US) LLP
1801 California Street
Suite 4900
Denver, CO 80202

Re: **Expedited Judicial Review**
15-3400GC Squire Patton Boggs 2013 Medicare Outliers - Banner Health CIRP Group
16-0244GC Squire Patton Boggs 2012-2013 Medicare Outlier - Allina Health CIRP Group
17-0507G Squire Patton Boggs 2013 Medicare Outliers - NPR Optional Group
17-2332G Squire Patton Boggs 2014 Medicare Outliers - NPR Optional Group II
17-1929G Squire Patton Boggs 2015 GA Medicare Outlier Group
18-0081GC Squire Patton Boggs - Banner Health 2015 Medicare Outliers CIRP Group
16-1459G Squire Patton Boggs 2014 Medicare Outliers Group
16-2096GC Squire Patton Boggs Lee Memorial 2014 Medicare Outliers CIRP
17-1751G Squire Patton Boggs 2015 Medicare Outliers - Optional Group
17-0536GC Squire Patton Boggs 2014 Medicare Outliers - Banner Health CIRP Group
17-0558GC Squire Patton Boggs 2014 Medicare Outliers - Allina Health CIRP Group

Dear Mr. Nash:

The Provider Reimbursement Review Board ("Board" or "PRRB") reviewed the Groups' Expedited Judicial Review ("EJR") Requests.[1] The Board determined that it grants jurisdiction in part and denies jurisdiction in part. The Board further determined that the Outlier Fixed Loss Threshold ("FLT") issue appealed by the Groups listed above is appropriate for EJR. This EJR decision closes Case Nos. 15-3400GC; 16-0244GC; 17-0507G; 17-2332G; 17-1929G; 18-0081GC; 16-1459G; 16-2096GC; 17-1751G; 17-0536GC; and, 17-0558GC. The Board's determination is outlined below.

[1] The Groups requested EJR on either Feb. 2 or Feb. 5, 2018 ("EJR Request").

Background

The issue under appeal is described as:

> Whether CMS reimbursed the providers for the full amount of the supplemental outlier payments to which the providers are entitled under the Social Security Act, §§ 1886(d)(5)(A)(i)-(iv) and (d)(3)(B); *see also* 42 U.S.C. §§ 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B).

In requesting EJR, the Groups stated:

> The Providers contend that the Medicare outlier regulations – specifically, the regulations found at 42 C.F.R. §§ 412.80 through 412.86 and the series of annual IPPS regulations resulting in establishing the Outlier Fixed Loss Threshold ("FLT") for their FYE . . . – are contrary to the Social Security Act and the intent of the Congress, are arbitrary and capricious, and are otherwise contrary to law. As a result, the FLTs established and used to calculate the Outlier Case Payments to which the Providers are entitled for [the corresponding] FYE . . . were invalid and must be recalibrated and reset, for the benefit of the Providers, so that the Providers may file amended and additional claims for Outlier Case Payments.[2]

The Board must decide whether to grant EJR as requested.

Board Determination

The regulation governing EJR states:

> (a)(1) This section implements provisions in section 1878(f)(1) of the Act that give a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
>
> . . .
>
> (f)(1) The Board's decision must grant EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines the following conditions are satisfied:
>
> (i) The Board has jurisdiction to conduct a hearing on the specific matter at issue . . .

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[2] EJR Request.

> (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.[3]

Therefore, the Board must first determine jurisdiction over the Group Participants before deciding whether it lacks the legal authority over the Outlier FLT issue.

Jurisdiction

In order to have a right to a Board hearing, the providers in the group must be dissatisfied with their final determinations of the total amount of reimbursement due the providers; the amount in controversy must be at least $50,000; the date of receipt by the Board of the providers' hearing request must be no later than 180 days after the date of receipt of the providers' final determinations; and, the matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group.[4] Effective for cost reporting periods that end on or after December 31, 2008, a provider preserves its right to claim dissatisfaction by either including a claim on its cost report, or self-disallowing the item by filing a cost report under protest.[5] All of the appeals addressed in this determination are required to protest the Outlier FLT in order for the Board to find jurisdiction. However, some of these appeals are from the untimely receipt of final determinations ("untimely NPR" appeals). In that instance, the statutory requirements for Board jurisdiction are somewhat different.

Under § 1878(a)(1)(B) or (C), (2), and (3) of the Social Security Act, a provider may obtain a Board hearing if: (1) the provider does not receive a final determination of the Medicare Contractor on a timely basis; (2) the amount in controversy is at least $10,000 (or $50,000 for a group); and, (3) the provider files a hearing request for a hearing to the Board within 180 days after notice of the Medicare Contractor's final determination would have been received if such determination had been issued on a timely basis. Moreover, § 405.1835(c) provides that a Medicare Contractor determination is not timely if it is not issued within 12 months of the Medicare Contractor's receipt of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of the regulations). Section 1878(a)(1)(B) of the Act does not require provider dissatisfaction for Board appeals based on untimely final Medicare Contractor determinations. This means that, if appealing from an "untimely NPR," there is no requirement to have a claim or protested amount for the issue under appeal.

The Board finds that all of the Group appeals met the amount in controversy requirement; however, it finds that there are other jurisdictional issues as outlined below.

Case No. 15-3400GC – Multiple Issues

Participant #4 (Prov. No. 03-0093), #11 (Prov. No. 03-0061), and #12 (Prov. No. 03-0130) originally filed their appeals based on "untimely NPRs." As cited above, § 405.1835(c) provides that the expiration date of the 12-month period for issuance of a timely NPR is calculated from the receipt of the provider's perfected or amended cost report. Participants #4, #11, and #12 each filed an amended cost report, which was accepted by the Medicare

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[3] 42 C.F.R. § 405.1842.

[4] *See* 42 C.F.R. §§ 405.1835, 405.1837.

[5] 42 C.F.R. § 405.1835(a).

Contractor. The Participants, however, did not appeal based on the amended cost report receipt dates (December 5, 2014).

Participant No.	Provider No.	Amended Cost Report Receipt Date	End of 12-month period	Appeal Date	NPR Date
4	03-0093	12/05/2014	12/05/2015	11/17/2015	10/01/2015
11	03-0061	12/05/2014	12/05/2015	11/17/2015	10/01/2015
12	03-0130	12/05/2014	12/05/2015	11/17/2015	

The above Participants filed their appeals with the Board on 11/17/2015, prior to the expiration of the 12-month period.

The Board finds that the amended cost report replaces and supersedes the originally filed cost report (*e.g.*, if the provider drops a cost or a protested item in the amended cost report that had been in the original, then the provider's rights relative to that cost or protested item are extinguished). To this end, the Medicare Contractor will only issue a final determination on the most recently filed and accepted cost report. When a provider files an amended cost report that is then accepted, the Medicare Contractor will not issue a final determination for any previously-filed cost report.[6]

The Board's finding is supported by § 405.1803(a) which requires that, "[u]pon receipt of a provider's cost report, or amended cost report where permitted or required, the contractor must within a reasonable period of time . . . furnish . . . a written notice reflecting the contractor's determination of the total amount of reimbursement . . . . " The Board's finding is further supported by § 405.1835(c)(1), which states that a provider has a right to appeal if a final contractor determination is not issued within 12 months after the date of receipt by the Medicare Contractor of the provider's *perfected or amended* cost report. If a provider files (and the Medicare Contractor accepts) an amended cost report, then the provider must file its "untimely NPR" appeal from the most recently accepted cost report's receipt date.

Each of the Participants filed their appeal requests prior to the expiration of the 12-month period based on their amended cost reports.[7] Based on this rationale, the Board dismisses the "untimely NPR" appeals for Participants #4, 11, and 12.

Following the timely issuance of their NPRs, Participant #4 and Participant #11 filed "Direct Add" Requests from their NPRs on March 29, 2016. The Board finds that the Providers protested the Outlier FLT on their cost reports and had an audit adjustment for the protested amounts. Therefore, the Board finds jurisdiction over the 3/29/2016 "Direct Add" Requests and only dismisses the "untimely NPR" appeal requests submitted on 11/17/2015. Participants #4 and #11 have jurisdictionally valid Outliers FLT appeals.

Participant #13 (Prov. 03-0016) filed a timely appeal from its NPR; however, its appeal is for a post-12/31/2008 cost report. This means that the provider is required to prove

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[6] Note that filing an amended cost report occurs before a final determination is issued. If a final determination has been issued and a provider seeks a change to its reimbursement, it must file a request to reopen under the provisions of 42 C.F.R. § 405.1885 and the Medicare Contractor must agree to reopen the provider's cost report. This is a separate process from filing an amended cost report.

[7] The Board recognizes that the NPR "due date" and the appeal date for Prov. No. 11-0054 are the same (05/27/2016); however, the Provider cannot appeal until "*after* notice of such determination would have been received." *See* § 1878(a)(3) of the Social Security Act.

dissatisfaction. As described in 42 C.F.R. § 405.1835(a), a provider has a right to a Board hearing only if it has preserved its right to claim dissatisfaction by including a claim for a specific item on its cost report or self-disallowing the specific item by filing a cost report under protest. There is evidence that protested amounts were adjusted during the audit of its cost report; however, Participant #13 provided no supporting documentation as evidence that it specifically protested the Outlier issue. Therefore, Participant #13 failed to protest the Outlier FLT as required by regulation and the Board dismisses the Participant from this case.[8]

The Board grants jurisdiction over the remaining providers.

Case No. 16-0244GC – Multiple Issues

Participants #1-#8 appealed from "untimely NPRs." These Participants did not file "untimely NPR" appeals from their most recently amended and accepted cost reports.

Participant No.	Provider No.	Amended Cost Report Receipt Date	End of 12-month period	Appeal Date	NPR Date
1	24-0057	07/27/2015	07/27/2016	11/17/2015	
2	24-0076	07/21/2015	07/21/2016	11/17/2015	12/31/2015
3	24-0020	07/17/2015	07/17/2016	11/17/2015	
4	24-0115	07/27/2015	07/27/2016	11/17/2015	
5	24-0069	09/04/2015	09/04/2016	11/17/2015	
6	24-0104	08/11/2015	08/11/2016	11/17/2015	01/26/2017
7	24-0038	07/22/2015	07/22/2016	11/17/2015	
8	24-0132	07/17/2015	07/17/2016	11/17/2015	

As described in the rationale above, the Board finds that Participants #1 (Prov. No. 24-0057); #3 (Prov. No. 24-0020); #4 (Prov. No. 24-0115); #5 (Prov. No. 24-0069); #7 (Prov. No. 24-0038); and, #8 (Prov. No. 24-0132) filed their appeal requests prior to the expiration of the 12-month period based on their amended cost reports. The Board hereby dismisses these Participants.

The Board also dismisses the "untimely NPR" appeals for Participants #2 (Prov. No. 24-0076) and #6 (Prov. No. 24-0104) as being prematurely filed (meaning the appeals were filed prior to the expiration of the 12-month period); however, Participants #2 and #6 subsequently filed "Direct Add" Requests for the Outlier issue from their NPRs. The Board finds that Participants #2 and #6 protested the Outliers issue in their cost reports as required by regulation. Therefore, although the Board dismisses their "untimely NPR" appeals, it finds jurisdiction over their "Direct Add" Requests filed from their NPRs. The NPR appeals for Participants #2 and #6 are the only appeals remaining in this case.

Participants #9 (Prov. No. 24-0059), #10 (Prov. No. 24-0059), and #11 (Prov. No. 24-0059) timely appealed from NPRs. Since they are appealing post-12/31/2008 cost reports, these Participants are required to file a cost report under protest for the Outliers

[8] The Board recognizes that, as there is no "claim" for the Outliers FLT on a cost report, the provider would be required to protest the Outlier FLT. The Board further recognizes that the Group Representative relied on the D.C. District Court's holding in *Banner Heart Hosp. v. Burwell*, No. 14-CV-01195(APM), 2016 WL 4435174 (D.D.C. Aug. 19, 2016) (holding that the self-disallowance regulation conflicted with the plain language of the Medicare statute); however, the Secretary has not taken action to amend the regulation. Therefore, the Board must comply with the self-disallowance regulation. *See* 42 C.F.R. § 405.1867.

issue. Participants #9-#11 failed to protest the Outlier issue as required by regulation. Therefore, the Board dismisses these Participants from the case.

Case No. 17-0507G – No Protested Amount

All Participants filed timely appeals from their NPRs. The Board finds that Participants #1 (Prov. No. 06-0027) and #3 (Prov. No. 51-0023) failed to protest the Outliers issue as required by regulation. The Board finds that, however, Participant #2 (Prov. No. 27-0057) protested the Outliers issue as required. Therefore, the Board dismisses Participants #1 and #3, but Participant #2's valid appeal will continue in this case.

Case No. 17-2332G – No Protested Amount

Both Participants timely filed appeals from their NPRs. However, only Participant #1 (Prov. No. 10-0087) protested Outliers on its cost report. Therefore, the Board hereby dismisses Participant #2 (Prov. No. 51-0001) for failing to prove dissatisfaction regarding the Outlier FLT issue by filing its cost report under protest. The Board finds that it has jurisdiction over Participant #1, and Participant #1 remains in this case.

Case No. 17-1929G – Premature Appeal

All Participants (Prov. Nos. 11-0054; 11-0079; and, 11-0036) appealed as post-12/31/2008 "untimely NPR" appeals. As cited above, § 405.1835(c) provides that the expiration date of the 12-month period for issuance of a timely NPR is calculated from the receipt of the provider's perfected or amended cost report. Participants #1 and #3 filed an amended cost report, which the Medicare Contractor accepted. These Participants, however, did not appeal based on the amended cost report receipt dates.

Participant No.	Provider No.	Cost Report Receipt Date	End of 12-month period	Appeal Date
1	11-0054	06/20/2016 (Amended)	06/20/2017	05/23/2017
2	11-0079	05/26/2016	05/26/2017	07/26/2017
3	11-0036	11/03/2017 (Amended)	11/03/2018	11/15/2017

To reiterate the Board's earlier explanation, the Board finds that the amended cost report replaces and supersedes the originally filed cost report (*e.g.*, if the provider drops a cost or a protested item in the amended cost report that had been in the original, then the provider's rights relative to that cost or protested item are extinguished). To this end, the Medicare Contractor will only issue a final determination on the most recently filed and accepted cost report. When a provider files an amended cost report that is then accepted, the Medicare Contractor will not issue a final determination for any previously-filed cost report.

The Board's finding is supported by § 405.1803(a) which requires that, "[u]pon receipt of a provider's cost report, or amended cost report where permitted or required, the contractor must within a reasonable period of time . . . furnish . . . a written notice reflecting the contractor's determination of the total amount of reimbursement . . . . " The Board's finding is further supported by § 405.1835(c)(1), which states that a provider has a right to appeal if a final contractor determination is not issued within 12 months after the date of receipt by the Medicare Contractor of the provider's *perfected or amended* cost report. If a provider files (and the Medicare Contractor accepts) an amended cost report, then the provider must file its "untimely NPR" appeal from the most recently accepted cost report's receipt date.

Participants #1 and #3 filed their appeal requests prior to the expiration of the 12-month period based on their amended cost reports.[9] Based on this rationale, the Board finds that it lacks jurisdiction over Participants #1 and #3 in this case. The Board finds that no evidence was submitted that Participant #2 filed an amended cost report. Participant #2 properly filed an "untimely NPR" appeal from its as-filed cost report, which was accepted. Therefore, the Board finds that it has jurisdiction over Participant #2.

Case No. 18-0081GC – Premature Appeal

All of the Participants in Case No. 18-0081GC filed "untimely NPR" appeals. However, some of the Participants did not file an appeal from their most recently submitted and accepted cost report. Some of the Participants had multiple amended cost reports accepted by the Medicare Contractor. Again, the Board finds that the most recently amended cost report (that is accepted) replaces and supersedes the originally filed cost report or a prior amended cost report.

Participant No.	Provider No.	Amended Cost Report Receipt Date	End of 12-month period	Appeal Date
3	03-0065	Not Provided	?	10/17/2017
4	03-0093	07/31/2017	07/31/2018	10/17/2017
8	03-0089	11/17/2016	11/17/2017	10/17/2017
11	03-0061	07/31/2017	07/31/2018	10/17/2017

The Board finds that Participants #3, #4, #8, and #11 filed their appeal requests on October 17, 2017. The appeal requests for Participants #4, #8, and #11 were all submitted prior to the end of the 12-month expiration period for timely issuance of a final determination, based on the amended cost report submissions. Participant #3 failed to provide the receipt date for its amended cost report.[10] 42 C.F.R. § 405.1835(c)(1) states that a provider has a right to appeal if a final contractor determination is not issued within 12 months after the date of receipt by the contractor of the provider's perfected or amended cost report. Further, Board Rule 7.4 requires that, if an appeal is based on the failure of the Medicare Contractor to timely issue a final determination, the hospital must provide evidence of the Medicare Contractor's receipt of the cost report ("the as-filed and any amended cost reports").[11] The Board is unable to verify the expiration of the 12-month period in order to grant jurisdiction over this appeal. The Board finds that Participant #3 failed to provide the Medicare Contractor's receipt date for its amended cost report as required. As noted in Board Rule 4.4, "[a]ppeals that fail to meet the jurisdictional requirements will be dismissed."[12] Consequently, the Board must dismiss Participant #3. Moreover, none of these Participants (#3, #4, #8, and #11) appealed their most recently amended and accepted cost report. Therefore, the Board finds that it lacks jurisdiction over Participants #3, #4, #8, and #11 and dismisses them from this case.

For the remaining Participants, no evidence was submitted that the Medicare Contractor accepted any amended cost reports. The Board finds that it has jurisdiction over the remaining providers who appealed from "untimely NPRs" from their as-filed cost reports.

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[9] The Board recognizes that the NPR "due date" and the appeal date for Prov. No. 11-0054 are the same (05/27/2016); however, the Provider cannot appeal until "*after* notice of such determination would have been received." *See* § 1878(a)(3) of the Social Security Act.

[10] The Schedule of Providers for Case No. 18-0081GC, Tab 3A (Feb. 2, 2018) shows that the Medicare Contractor accepted the amended cost report on 11/29/2016.

[11] Board Rule 7.4 at 7 (Jul. 1, 2015).

[12] Board Rule 4.4 at 3.

The case will continue with Participants #1 (Prov. No. 03-0105); #2 (Prov. No. 03-0088); #5 (Prov. No. 03-0115); #6 (Prov. No. 03-0122); #7 (Prov. No. 03-0002); #9 (Prov. No. 06-0030); #10 (Prov. No. 06-0001); #12 (Prov. No. 03-0016); and, #13 (Prov. No. 03-0130).

Case No. 16-1459G – Multiple Issues

All of the Participants in Case No. 16-1459G filed appeals from "untimely NPRs." Two of those Participants, Participant #1 (Prov. No. 27-0004) and Participant #2 (Prov. No. 05-0471) also appealed from their NPRs. Participant #2 had a timely NPR issued for the applicable 2014 FYE.

Participant No.	Provider No.	Cost Report Receipt Date	End of 12-month period	Appeal Date	NPR Date
1	27-0004	12/01/2014	12/01/2015	04/11/2016	08/01/2016
2	05-0471	12/22/2015 (Amended)	12/22/2016	04/11/2016	12/20/2016
3	51-0055	01/08/2016	01/08/2017	07/06/2016	
4	51-0022	05/29/2015	05/29/2016	09/12/2016	
5	06-0011	04/14/2016 (Amended)	04/14/2017	09/09/2016	
6	10-0017	02/25/2015	02/25/2016	08/15/2016	
7	10-0087	02/25/2015	02/25/2016	07/21/2016	
8	27-0057	06/01/2015	06/01/2016	09/22/2016	
9	51-0001	08/18/2016 (Amended)	08/18/2017	09/09/2016	
10	06-0075	06/08/2015	06/08/2016	11/25/2016	
11	06-0027	06/01/2015	06/01/2016	11/23/2016	

As stated, Participant #1 (Prov. No. 27-0004) appealed the Outlier FLT issue from its "untimely NPR" and its NPR. The Board finds that both of its appeals were timely. Further, the Board finds that Participant #1 appropriately protested outliers in its cost report as required, with an audit adjustment to its Protested Amount. The Board, therefore, finds jurisdiction over the Outlier FLT appeal for Participant #1 for FYE 2014.

Participant #2 (Prov. No. 05-0471) filed its "untimely NPR" appeal prior to the expiration of the 12-month period. Participant #2 also failed to appeal from its most recently accepted amended cost report. As previously explained, the Board finds that the amended cost report replaces and supersedes the originally filed cost report. In fact, Participant #2 received its timely NPR on 12/20/2016. Participant #2 also filed an appeal from that NPR. Further, the Board finds that Participant #2 submitted proof that it protested outlier payments on its cost report, which were audited. Therefore, the Board dismisses the "untimely NPR" appeal for Participant #2, but grants jurisdiction over the NPR appeal.

Participant #5 (Prov. No. 06-0011) and Participant #9 (Prov. No. 51-0001) also submitted amended cost reports that were accepted by the Medicare Contractor. These Participants failed to appeal from their amended cost reports. These Participants also appealed prior to the expiration of the 12-month period following the Medicare Contractor's receipt of their amended cost reports. Therefore, the Board dismisses Participants #5 and #9 from the case.

Participants #3 (Prov. No. 51-0055); #4 (Prov. No. 51-0022); #6 (Prov. No. 10-0017); #7 (Prov. No. 10-0087); #8 (Prov. No. 27-0057); #10 (Prov. No. 06-0075); #11 (Prov. No. 06-0027) all appealed as "untimely NPR" appeals. The Board finds that these Participants timely filed from the receipt date of their accepted as-filed cost reports. There was no evidence submitted that these Participants submitted amended cost reports that were accepted by the Medicare Contractor. The Board grants jurisdiction over Participants #3, #4, #6, #7, #8, #10, and #11.

Case No. 16-2096GC – Multiple Issues

All 3 Participants in this case filed appeals from "untimely NPRs." Participant #1 (Prov. No. 10-0220) timely filed an appeal from its as-filed (and accepted) cost report. The as-filed cost report was received by the Medicare Contractor on 3/3/2015 and the appeal was timely filed on 7/12/2016, after the expiration of the 12-month period (3/3/2016). Therefore, the Board finds jurisdiction over Participant #1.

Participants #2 (Prov. No. 10-0012) and #3 (Prov. No. 10-0244) filed two "untimely NPR" appeals. First, the Participants filed appeals from their as-filed cost reports and subsequently from their amended cost reports. 42 C.F.R. § 405.1835(c)(1) states that a final contractor determination must be issued within 12 months after the date of receipt by the Medicare Contractor of the provider's *perfected or amended* cost report. The Board finds that the amended cost report replaces and supersedes the as-filed (or original) cost report. Only one of the cost reports will result in the issuance of a final determination (the most recently accepted cost report). The Board finds that the "as-filed" (or original) cost report was superseded by the amended cost report. Therefore, the Board dismisses the "untimely NPR" appeals of the original cost reports. The Board grants jurisdiction for Participants #2 and #3 for the amended cost report appeals.

Case No. 17-1751G – Multiple Issues

Most of the Participants in Case No. 17-1751G filed from "untimely NPR" appeals; however, one Participant, Participant #5 (Prov. No. 27-0004), filed an appeal from its NPR. The Board finds that Participant #5 filed a timely appeal and provided evidence that it protested the Outliers issue on its cost report (Audit Adjustment No. 23). The Board, therefore, grants jurisdiction over Participant #5.

Participant No.	Provider No.	Cost Report Receipt Date	End of 12-month period	Appeal Date
3	10-0087	03/31/2017	03/31/2018	06/28/2017
6	06-0027	10/26/2017	10/26/2018	07/28/2017
9	06-0075	09/27/2016 (Amended)	09/27/2017	12/08/2017
10	51-0001	07/25/2017	07/25/2018	08/09/2017

The Board finds that Participants #3, #6, and #10 filed "untimely NPR" appeals prior to the expiration of the 12-month period. Therefore, the Board finds that it lacks jurisdiction over these appeals since they are premature. In other words, the respective Medicare Contractor may still issue a timely NPR. Participants #3, #6, and #10 are hereby dismissed from Case No. 17-1751G.

Participant #9 filed 2 "untimely NPR" appeals: one from its as-filed cost report and one from its amended cost report. As § 405.1835(c)(1) states, the appeal from an untimely NPR is based on the *perfected or amended* cost report. Also, the Board finds that the amended

cost report replaces and supersedes the originally-filed cost report. Therefore, the Board dismisses Participant #9's appeal from the original/as-filed cost report, but maintains jurisdiction over the amended cost report.

The Board finds that it has jurisdiction over the remaining Participants in this case.

Case No. 17-0536G – Multiple Issues

Participants #1 (Prov. No. 03-0105); #2 (Prov. No. 03-0088); #3 (Prov. No. 03-0065); #6 (Prov. No. 03-0122); and, #8 (Prov. No. 03-0089) appealed from "untimely NPRs" and issued NPRs. The Board finds that, in their NPR appeals, the Participants validly protested Outliers. The Board further finds that the "untimely NPR" appeals are jurisdictionally valid. Therefore, the Board determines that it has jurisdiction over the Outlier FLT issue for Participants #1, #2, #3, #6, and #8 for FYE 2014.

Participant #13 appealed from its NPR for FYE 2014. The Participant did not file the Outliers issue under protest, or claim Outliers on its cost report pursuant to 42 C.F.R. § 405.1835. Therefore, the Board determines it lacks jurisdiction over Participant #13 and hereby dismisses this Participant from the case.

The Board finds jurisdiction over the remaining Participants in Case No. 17-0536G.

Case No. 17-0558GC – Premature Appeal

Participant #1 (Prov. No. 24-0057) has 2 "untimely NPR" appeals, each from an amended cost report submission. As previously explained throughout this decision, the Provider can only have one "untimely NPR" appeal since an NPR will only be issued from the most recently accepted perfected or amended cost report. Therefore, the Board dismisses the "untimely NPR" appeal filed on 11/23/2016 from a previously-filed amended cost report that was superseded.

The Board grants jurisdiction over the remaining Providers in Case No. 17-0558GC.

Legal Authority

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit EJR if the Board determines that it does not have the authority to decide a question of law, regulation, or CMS Ruling. In this case, the Group challenges the validity of the Secretary's outlier determination under 42 U.S.C. §§ 1395ww(d)(3)(B) and (d)(5)(A) (Outlier Statutes); 42 C.F.R. §§ 412.80 through 412.86; and, the series of annual IPPS regulations resulting in establishing the applicable Outlier Fixed Loss Threshold ("FLT"). The Groups state that the Board lacks the authority to decide the specific legal question posed by the Groups, namely that the Providers have not been paid the full amount of outlier payments to which they are entitled under the Outlier Statutes.[13] Specifically, the legal question is:

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulation [set forth at 42 C.F.R. § 412.80 through 412.86] and the fixed loss threshold ("FLT") Regulations [set forth in the annual "Medicare Program; Hospital Inpatient Prospective Payment Systems and Fiscal Year Rates"]—as

[13] EJR Request at 1.

> promulgated by the Secretary . . . and [CMS], and as in effect for the appealed years, are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid?[14]

The Groups argue that the Outlier statute has been interpreted by the Secretary to mean that, prior to the start of each fiscal year, the Secretary must establish a FLT that is projected to pay out total Outlier Case Payments in an amount equal to 5.1% of projected DRG payments for that year.[15] However, influenced by "turbo-charging," the Secretary began increasing FLTs in an attempt to stay at 5.1%.[16] The Groups argue that CMS improperly kept the FLT at $33,560 between FYs 2003-2010.[17] The Group also states that CMS "repeatedly set the FLT at levels which paid out significantly less than the agency's stated target of 5.1% of total IPPS payments."[18] The Group contends that the Secretary also refused to make adjustments even after the regulations (revised in 2003) called for an audit and reconciliation of Outlier Case Payments made to any providers who appeared to continue to engage in "turbo-charging."[19] Further, because CMS failed to account for the turbo-charging hospitals' effect on Outlier payments, CMS failed to follow the Outlier Statute (approximating the marginal cost of care) and wrongfully included inflated Outlier payments in projecting the FLT.[20] Reliance on such data lead to artificially high FLTs.[21] The Groups challenge the validity of the Secretary's set FLT for the fiscal years at issue.

The Board finds that the outlier issue properly falls within the provisions of 42 C.F.R. § 405.1842 since it is a challenge to the substantive validity of the Secretary's application of the outlier statutes and regulations. The Board lacks the authority to determine whether the Secretary's outlier threshold was valid. The Board agrees with the Groups that it lacks legal authority in these cases. The Board finds that:

> (1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board except as otherwise noted above;
>
> (2) Based upon the Providers' assertions regarding 42 U.S.C. §§ 1395ww(d)(3)(B) and (d)(5)(A); 42 C.F.R. §§ 412.80 through 412.86; and, the IPPS Final Rules setting the FLT, there are no findings of fact for resolution by the Board;
>
> (3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and,
>
> (4) It is without the authority to decide the legal question of whether the Secretary's fixed loss threshold for outlier payments is valid.

Accordingly, the Board finds that the outlier issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Groups' Request for EJR for the issue and

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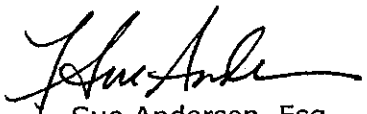
[14] *Id.* at 2.
[15] *Id.* at 4.
[16] *Id.* at 5.
[17] *Id.* at 9.
[18] *Id.* at 10.
[19] *Id.*
[20] *Id.* at 13.
[21] *Id.* at 18.

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

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

FOR THE BOARD:



L. Sue Andersen, Esq.
Chairperson

Enclosure: Schedules of Providers

cc: Laurie Polson, Appeals Lead, Palmetto GBA c/o National Government Services (Case Nos. 17-1751G; 17-0507G; 16-1459G; 17-1751G)

Byron Lamprecht, Cost Report Appeals, Wisconsin Physicians Service (Case Nos. 17-0536GC; 15-3400GC; 18-0081GC; 17-0536GC)

Geoff Pike, First Coast Service Options, Inc. (Case Nos. 17-2332G; 16-2096GC)

Cecile Huggins, Palmetto GBA (Case No. 17-1929G)

Danene Hartley, Appeals Lead, National Government Services (Case Nos. 16-0244GC; 17-0558GC)

Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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PRRB Case Nos. 16-1649GC; 16-2333GC; 16-2530G; 17-2022GC MAR 02 2018

CERTIFIED MAIL

Stephen P. Nash
Squire Patton Boggs (US) LLP
1801 California Street
Suite 4900
Denver, CO 80202

Re: **Expedited Judicial Review**
PRRB Case Nos.: **16-1649GC** (FYE 06/30/2013)
Squire Patton Boggs 2013 Medicare Outliers - St. Joseph's/Candler CIRP Group

16-2333GC (FYE 12/31/2014)
Squire Patton Boggs 2014 Medicare Outliers - St. Joseph's/Candler NPR CIRP Group

16-2530G (FYE 12/31/2014)
Squire Patton Boggs 2014 GA Medicare Outliers Group

17-2022GC (FYE 12/31/2015)
Squire Patton Boggs 2015 Medicare Outliers - Allina Health CIRP Group

Dear Mr. Nash:

The Provider Reimbursement Review Board ("Board" or "PRRB") reviewed the Groups' Expedited Judicial Review ("EJR") Requests.[1] The Board determined that it lacks jurisdiction over the Providers in these Groups. This decision closes Case Nos. 16-1649GC; 16-2333GC; 16-2530G; and, 17-2022GC. The Board's determination is outlined below.

Background

The issue under appeal is described as:

> Whether CMS reimbursed the providers for the full amount of the supplemental outlier payments to which the providers are entitled under the Social Security Act, §§ 1886(d)(5)(A)(i)-(iv) and (d)(3)(B); *see also* 42 U.S.C. §§ 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B).

[1] The Groups requested EJR on either Feb. 2 or Feb. 5, 2018 ("EJR Request").

In requesting EJR, the Groups stated:

> The Providers contend that the Medicare outlier regulations – specifically, the regulations found at 42 C.F.R. §§ 412.80 through 412.86 and the series of annual IPPS regulations resulting in establishing the Outlier Fixed Loss Threshold ("FLT") for their FYE . . . – are contrary to the Social Security Act and the intent of the Congress, are arbitrary and capricious, and are otherwise contrary to law. As a result, the FLTs established and used to calculate the Outlier Case Payments to which the Providers are entitled for [the corresponding] FYE . . . were invalid and must be recalibrated and reset, for the benefit of the Providers, so that the Providers may file amended and additional claims for Outlier Case Payments.[2]

The Board must decide whether to grant EJR as requested.

Board Determination

The regulation governing EJR states:

> (a)(1) This section implements provisions in section 1878(f)(1) of the Act that give a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
>
> . . .
>
> (f)(1) The Board's decision must grant EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines the following conditions are satisfied:
>
> (i) The Board has jurisdiction to conduct a hearing on the specific matter at issue . . .
>
> (ii) The Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[3]

Therefore, the Board must first determine jurisdiction over the Group Participants before deciding whether it lacks the legal authority over the Outlier FLT issue.

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[2] EJR Request.

[3] 42 C.F.R. § 405.1842.

Jurisdiction

In order to have a right to a Board hearing, the providers in the group must be dissatisfied with their final determinations of the total amount of reimbursement due the providers; the amount in controversy must be at least $50,000; the date of receipt by the Board of the providers' hearing request must be no later than 180 days after the date of receipt of the providers' final determinations; and, the matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group.[4] Effective for cost reporting periods that end on or after December 31, 2008, a provider preserves its right to claim dissatisfaction by either including a claim on its cost report, or self-disallowing the item by filing a cost report under protest.[5] All of the appeals addressed in this determination are required to protest the Outlier FLT in order for the Board to find jurisdiction. However, some of these appeals are from the untimely receipt of final determinations ("untimely NPR" appeals). In that instance, the statutory requirements for Board jurisdiction are somewhat different.

Under § 1878(a)(1)(B) or (C), (2), and (3) of the Social Security Act, a provider may obtain a Board hearing if: (1) the provider does not receive a final determination of the Medicare Contractor on a timely basis; (2) the amount in controversy is at least $10,000 (or $50,000 for a group); and, (3) the provider files a hearing request for a hearing to the Board within 180 days after notice of the Medicare Contractor's final determination would have been received if such determination had been issued on a timely basis. Moreover, § 405.1835(c) provides that a Medicare Contractor determination is not timely if it is not issued within 12 months of the Medicare Contractor's receipt of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of the regulations). Section 1878(a)(1)(B) of the Act does not require provider dissatisfaction for Board appeals based on untimely final Medicare Contractor determinations. This means that, if appealing from an "untimely NPR," there is no requirement to have a claim or protested amount for the issue under appeal.

The Board finds that all of the Group appeals met the amount in controversy requirement; however, it finds that there are other jurisdictional issues as outlined below.

Case No. 16-1649GC – No Protested Amount

Both Participants (Prov. Nos. 11-0043 and 11-0024) filed timely appeals from their NPRs; however, both are appealing from post-12/31/2008 cost reports. This means that the Participants are required to prove dissatisfaction. As described in 42 C.F.R. § 405.1835(a), a provider has a right to a Board hearing only if it has preserved its right to claim dissatisfaction by including a claim for a specific item on its cost report or self-disallowing the specific item by filing a cost report under protest. Here, neither Participant protested the Outlier FLT as required by regulation.[6] Therefore, the Board dismisses both Participants and closes this case.

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[4] *See* 42 C.F.R. §§ 405.1835, 405.1837.

[5] 42 C.F.R. § 405.1835(a).

[6] The Board recognizes that, as there is no "claim" for the Outliers FLT on a cost report, the provider would be required to protest the Outlier FLT. The Board further recognizes that the Group Representative relied on the D.C. District Court's holding in *Banner Heart Hosp. v. Burwell*, No. 14-CV-01195(APM), 2016 WL 4435174 (D.D.C. Aug. 19, 2016) (holding that the self-disallowance regulation conflicted with the plain language of the Medicare statute); however, the Secretary has not taken action to amend the regulation. Therefore, the Board must comply with the self-disallowance regulation. *See* 42 C.F.R. § 405.1867.

Case No. 16-2333GC – No Protested Amount

Both Participants (Prov. Nos. 11-0043 and 11-0024) filed timely appeals from their NPRs; however, both of these appeals are for post-12/31/2008 cost reports and both Participants failed to protest the Outlier FLT. Therefore, the Board dismisses these Participants and closes this case.

Case No. 16-2530G – Premature Appeal

All Participants (Prov. Nos. 11-0054; 11-0036; and, 11-0079) appealed as post-12/31/2008 "untimely NPR" appeals. As cited above, § 405.1835(c) provides that the expiration date of the 12-month period for issuance of a timely NPR is calculated from the receipt of the provider's perfected or amended cost report. Each of the Participants filed an amended cost report, which the Medicare Contractor accepted. The Participants, however, did not appeal based on the amended cost report receipt dates.

Provider No.	Amended Cost Report Receipt Date	End of 12-month period	Appeal Date
11-0054	05/27/2015	05/27/2016	05/27/2016
11-0036	11/03/2017	11/03/2018	09/20/2016
11-0079	07/08/2016	07/08/2017	11/15/2016

The Board finds that the amended cost report replaces and supersedes the originally filed cost report (*e.g.*, if the provider drops a cost or a protested item in the amended cost report that had been in the original, then the provider's rights relative to that cost or protested item are extinguished). To this end, the Medicare Contractor will only issue a final determination on the most recently filed and accepted cost report. When a provider files an amended cost report that is then accepted, the Medicare Contractor will not issue a final determination for any previously-filed cost report.[7]

The Board's finding is supported by § 405.1803(a) which requires that, "[u]pon receipt of a provider's cost report, or amended cost report where permitted or required, the contractor must within a reasonable period of time . . . furnish . . . a written notice reflecting the contractor's determination of the total amount of reimbursement . . . . " The Board's finding is further supported by § 405.1835(c)(1), which states that a provider has a right to appeal within 12 months after the date of receipt by the Medicare Contractor of the provider's *perfected or amended* cost report. If a provider files (and the Medicare Contractor accepts) an amended cost report, then the provider must file its "untimely NPR" appeal from the most recently accepted cost report's receipt date.

Each of the Participants filed their appeal requests prior to the expiration of the 12-month period based on their amended cost reports.[8] Based on this rationale, the Board finds that it lacks jurisdiction over all 3 Participants in this case. Therefore, the Board dismisses all 3 Participants and closes this case.

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[7] Note that filing an amended cost report occurs before a final determination is issued. If a final determination has been issued and a provider seeks a change to its reimbursement, it must file a request to reopen under the provisions of 42 C.F.R. § 405.1885 and the Medicare Contractor must agree to reopen the provider's cost report. This is a separate process from filing an amended cost report.

[8] The Board recognizes that the NPR "due date" and the appeal date for Prov. No. 11-0054 are the same (05/27/2016); however, the Provider cannot appeal until "*after* notice of such determination would have been received." *See* § 1878(a)(3) of the Social Security Act.

Case No. 17-2022GC – Premature Appeal

All of the Participants in Case No. 17-2022GC filed "untimely NPR" appeals. However, none of the Participants filed an appeal from their most recently submitted and accepted cost report. Here, the Participants had multiple amended cost reports accepted by the Medicare Contractor. Again, the Board finds that the most recently amended cost report (that is accepted) replaces and supersedes the originally filed cost report or a prior amended cost report.

Provider No.	Second Amended Cost Report Receipt Date	End of 12-month period	Appeal Date
24-0057	07/31/2017	07/31/2018	08/04/2017
24-0076	03/24/2017	03/24/2018	08/04/2017
24-0020	08/11/2017	08/11/2018	08/04/2017
24-0115	04/07/2017	04/07/2018	08/04/2017
24-0069	08/30/2017	08/30/2018	08/04/2017
24-0104	03/27/2017	03/27/2018	08/04/2017
24-0038	03/09/2017	03/09/2018	08/04/2017
24-0132	07/31/2017	07/31/2018	08/04/2017
24-0059	08/03/2017	08/03/2018	08/04/2017

The Board finds that each of the Participants filed their appeal requests on August 4, 2017. These appeal requests were all submitted prior to the end of the 12-month expiration period for timely issuance of a final determination, based on the amended cost report submissions. Further, none of the Participants appealed their most recently amended and accepted cost report. Therefore, the Board finds that it lacks jurisdiction in this case. The Board dismisses all 9 Participants and closes this case.

Based on the above, the Board determined that it lacks jurisdiction over Case Nos. 16-1649GC; 16-2333GC; 16-2530G; and, 17-2022GC. These cases are hereby closed. Therefore, the Board does not reach the question of whether it has the legal authority to decide the Outlier FLT issue. 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
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

Enclosure: Schedules of Providers

cc: Cecile Huggins, Palmetto GBA (Case No. 16-1649GC; Case No. 16-2333GC; 16-2530G)

Danene Hartley, Appeals Lead, National Government Services (Case No. 17-2022GC)

Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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MAR 02 2018

PRRB Case Nos. 13-3457GC; 15-3243GC; 17-1739GC; 17-1613GC

CERTIFIED MAIL

Stephen P. Nash
Squire Patton Boggs (US) LLP
1801 California Street
Suite 4900
Denver, CO 80202

Re: **Expedited Judicial Review**
PRRB Case Nos.: **13-3457GC** (FYE 12/31/2008)
Patton Boggs 2008 Medicare Outliers - Allina Health CIRP Group

15-3243GC (FYE 09/30/2013)
Squire Patton Boggs - Lee Memorial 2013 Medicare Outliers CIRP Group

17-1739GC (FYE 09/30/2015)
Squire Patton Boggs - Lee Health 2015 Medicare Outliers CIRP Group

17-1613GC (FYE 06/30/2015)
Squire Patton Boggs 2015 Medicare Outliers - St. Joseph's/Candler CIRP Group

Dear Mr. Nash:

The Provider Reimbursement Review Board ("Board" or "PRRB") reviewed the Groups' Expedited Judicial Review ("EJR") Requests.[1] The Board determined that it has jurisdiction over the providers in these Groups. The Board further determined that the Outlier Threshold issue appealed by the Groups listed above is appropriate for EJR. This EJR decision closes Case Nos. 13-3457GC; 15-3243GC; 17-1739GC; and, 17-1613GC. The Board's determination is outlined below.

Background

The issue under appeal is described as:

> Whether CMS reimbursed the providers for the full amount of the supplemental outlier payments to which the providers are entitled under the Social Security Act, §§ 1886(d)(5)(A)(i)-(iv) and (d)(3)(B); *see also* 42 U.S.C. §§ 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B).

[1] The Groups requested EJR on either Feb. 2 or Feb. 5, 2018 ("EJR Request").

In requesting EJR, the Groups stated:

> The Providers contend that the Medicare outlier regulations – specifically, the regulations found at 42 C.F.R. §§ 412.80 through 412.86 and the series of annual IPPS regulations resulting in establishing the Outlier Fixed Loss Threshold ("FLT") for their FYE . . . – are contrary to the Social Security Act and the intent of the Congress, are arbitrary and capricious, and are otherwise contrary to law. As a result, the FLTs established and used to calculate the Outlier Case Payments to which the Providers are entitled for [the corresponding] FYE . . . were invalid and must be recalibrated and reset, for the benefit of the Providers, so that the Providers may file amended and additional claims for Outlier Case Payments.[2]

Board Determination

The regulation governing EJR states:

> (a)(1) This section implements provisions in section 1878(f)(1) of the Act that give a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
>
> . . .
>
> (f)(1) The Board's decision must grant EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines the following conditions are satisfied:
>
> (i) The Board has jurisdiction to conduct a hearing on the specific matter at issue . . .
>
> (ii) The Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[3]

Therefore, the Board must first determine jurisdiction over the Group Participants before deciding whether it lacks the legal authority over the Outlier FLT issue.

Jurisdiction

In order to have a right to a Board hearing, the providers in the group must be dissatisfied with their final determinations of the total amount of reimbursement due the

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[2] EJR Request.
[3] 42 C.F.R. § 405.1842.

providers; the amount in controversy must be at least $50,000; the date of receipt by the Board of the providers' hearing request must be no later than 180 days after the date of receipt of the providers' final determinations; and, the matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group.[4] All of these appeals are for cost reporting periods after 12/31/2008; therefore, the requirement to protest the Outlier FLT is necessary for the Board to find jurisdiction. However, most of these appeals are from untimely receipt of final determinations ("untimely NPR" appeals). In that instance, the statutory requirements for Board jurisdiction are somewhat different.

Under § 1878(a)(1)(B) or (C), (2), and (3) of the Social Security Act, a provider may obtain a Board hearing if: (1) the provider does not receive a final determination of the Medicare Contractor on a timely basis; (2) the amount in controversy is at least $10,000 (or $50,000 for a group); and, (3) the provider files a hearing request for a hearing to the Board within 180 days after notice of the Medicare Contractor's final determination would have been received if such determination had been issued on a timely basis. Moreover, § 405.1835(c) provides that a Medicare Contractor determination is not timely if it is not issued within 12 months of the Medicare Contractor's receipt of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of the regulations). Section 1878(a)(1)(B) of the Act does not require provider dissatisfaction for Board appeals based on untimely final Medicare Contractor determinations. This means that, if appealing from an "untimely NPR," there is no requirement to have a claim or protested amount for the issue under appeal.

The Board finds that all of the Group appeals met the amount in controversy requirement. Further, all of the Providers had timely appeals from their final determinations or untimely NPRs. In Case No. 13-3457GC, both providers appealed from NPRs; however, they protested Outliers on their cost reports and had audit adjustments for the protested amounts. The remaining Providers in Case Nos. 15-3243GC, 17-1739GC, and 17-1613GC appealed from untimely NPRs and were not required to protest Outliers. Therefore, the Board finds that it has jurisdiction in these cases.

Legal Authority

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit EJR if the Board determines that it does not have the authority to decide a question of law, regulation, or CMS Ruling. In this case, the Group challenges the validity of the Secretary's outlier determination under 42 U.S.C. §§ 1395ww(d)(3)(B) and (d)(5)(A) (Outlier Statutes); 42 C.F.R. §§ 412.80 through 412.86; and, the series of annual IPPS regulations resulting in establishing the applicable Outlier Fixed Loss Threshold ("FLT"). The Groups state that the Board lacks the authority to decide the specific legal question posed by the Groups, namely that the Providers have not been paid the full amount of outlier payments to which they are entitled under the Outlier Statutes.[5] Specifically, the legal question is:

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources—the Outlier Payment Regulation [set forth at 42 C.F.R. § 412.80 through 412.86] and the fixed loss threshold ("FLT") Regulations [set forth in the annual "Medicare Program; Hospital Inpatient Prospective Payment Systems and Fiscal Year Rates"]—as promulgated by the Secretary . . . and [CMS], and as in effect

[4] 42 C.F.R. § 405.1837.

[5] EJR Request at 1.

for the appealed years, are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid?[6]

The Groups argue that the Outlier statute has been interpreted by the Secretary to mean that, prior to the start of each fiscal year, the Secretary must establish a FLT that is projected to pay out total Outlier Case Payments in an amount equal to 5.1% of projected DRG payments for that year.[7] However, influenced by "turbo-charging," the Secretary began increasing FLTs in an attempt to stay at 5.1%.[8] The Groups argue that CMS improperly kept the FLT at $33,560 between FYs 2003-2010.[9] The Group also states that CMS "repeatedly set the FLT at levels which paid out significantly less than the agency's stated target of 5.1% of total IPPS payments."[10] Further, because CMS failed to account for the turbo-charging hospitals' effect on Outlier payments, CMS failed to follow the Outlier Statute (approximating the marginal cost of care) and wrongfully included inflated Outlier payments in projecting the FLT.[11] Reliance on such data lead to artificially high FLTs.[12] The Groups challenge the validity of the Secretary's set FLT for the fiscal years at issue.

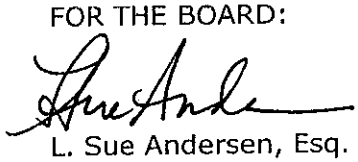
The Board finds that the outlier issue properly falls within the provisions of 42 C.F.R. § 405.1842 since it is a challenge to the substantive validity of the Secretary's application of the outlier statutes and regulations. The Board lacks the authority to determine whether the Secretary's outlier threshold was valid. The Board agrees with the Groups that it lacks legal authority in these cases. The Board finds that:

(1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
(2) Based upon the Providers' assertions regarding 42 U.S.C. §§ 1395ww(d)(3)(B) and (d)(5)(A); 42 C.F.R. §§ 412.80 through 412.86; and, the IPPS Final Rules setting the FLT, there are no findings of fact for resolution by the Board;
(3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and,
(4) It is without the authority to decide the legal question of whether the Secretary's fixed loss threshold for outlier payments is valid.

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

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

FOR THE BOARD:



L. Sue Andersen, Esq.
Chairperson

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[6] *Id.* at 2.
[7] *Id.* at 4.
[8] *Id.* at 5.
[9] *Id.* at 9.
[10] *Id.* at 10.
[11] *Id.* at 13.
[12] *Id.* at 18.

Enclosure: Schedules of Providers

cc: Danene Hartley, Appeals Lead, National Government Services (Case No. 13-3457GC)

Geoff Pike, First Coast Service Options, Inc. (Case Nos. 15-3243GC; 17-1739GC)

Cecile Huggins, Palmetto GBA (Case No. 17-1613GC)

Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAR 02 2018

Certified Mail

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

RE: **EJR Determination**

13-3100GC	HRS FMOLHS 2008 DSH Medicare Managed Care Part C Days Group
13-3303GC	HRS FMOLHS 2009 DSH Medicare Managed Care Part C Days Group
13-3344GC	HRS FMOLHS 2007 DSH Medicare Managed Care Part C Days Group
14-1035GC	HRS UHHS 2007 DSH Medicare Managed Care Part C Days Group
14-1767GC	HRS UHHS 2006 DSH SSI Fraction Medicare Managed Care Part C Days Group
14-2313GC	HRS UHHS 2009 DSH SSI Fraction Medicare Managed Care Part C Days Group
14-2315GC	HRS UHHS 2009 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
15-0799GC	HRS FMOLHS 2007 SSI Fraction Medicare Managed Care Part C Days Group

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 19, 2018 request for expedited judicial review (EJR) (received February 21, 2018) The Board's decision with respect to jurisdiction and EJR is set forth below.

Issue in Dispute

The issue in dispute in these cases is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total 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 (Allina I),*[20] vacated the FFY 2005 IPPS rule. However, the Secretary has not acquiesced to that decision. More recently in *Allina Health Services v.* Price *(Allina II),*[21] the Court found that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction was vacated by *Allina Health Services* above. The Court found that the Secretary was required to undertake notice and comment ruling-making and the 2012 regulation was invalid. Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

The Providers explain that because the Secretary has not acquiesced to the decision in *Allina,* the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (the 2004 Rule). The Board is bound by the 2004 rule and the Providers and the Providers contend that the Board should grant their request for EJR.

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

Decision of the Board

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

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[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] 2017 WL 3137976 (D.C. Cir. July 25, 2017).

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006, 2007, 2008 and 2009.

For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that ends on or before December 30, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[22] With respect to a participant's appeals filed from a cost reporting period that ends on or after December 31, 2008, in order to demonstrate dissatisfaction with the amount of Medicare payment for the appealed issue, a participant filing an appeal from an original NPR must show that the Medicare contractor adjusted its SSI fraction when it settled the participant's cost report or the participant must have self-disallowed the appealed issue by filing its cost report under protest.[23]

The Board has determined that the participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[24] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request span fiscal years 2006, 2007, 2008 and 2009, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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[22] 108 S.Ct. 1255 (1988).
[23] *See* 42 C.F.R. § 405.1835 (2008).
[24] *See* 42 C.F.R. § 405.1837.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

RE: 17-1744

MAR 0 2 2018

CERTIFIED MAIL

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

RE: Springs Memorial Hospital
Provider No. 42-0036
FYE 11/30/2014
PRRB Case No. 17-1744

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed correspondence from you, dated February 7, 2018 (received by the Board on February 20, 2018). The correspondence, which is a copy of a cover letter addressed to the Medicare Contractor, transmits the Provider's preliminary position paper. In addition, it advises that all issues, except Medicaid Eligible Days and SSI Provider Specific, have been transferred to group appeals.

Upon review the Board notes that this case was dismissed by the Board on July 18, 2017 because the appeal was not filed in conformance with 42 C.F.R. § 405.1835 and the Board Rules as it did not include a copy of the final determination in dispute. If you disagree with the Board's dismissal, you may request a reinstatement of the appeal under Rule 46 of the PRRB rules. PRRB Rule 46.1, in part, states:

> A Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the Provider's withdrawal of the issue(s) (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions).

By letter dated February 21, 2018, Quality Reimbursement Services filed five (5) Form Ds requesting the transfer of the following issues from the subject appeal to pending CIRP ("Common Issue Related Party") groups:

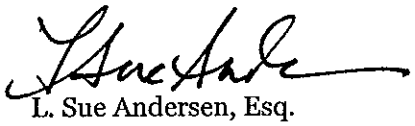
Issue #2 - DSH SSI (Systemic Errors) to case number 18-0109GC
Issue #4 - DSH Payment - SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days and No-Pay Part A Days) to case number 18-0110GC
Issues #6 & 9 - DSH Payment-Medicare Fraction Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days and No-Pay Part A Days) AND DSH Payment-Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days and No-Pay Part A Days) to case number 18-0111GC
Issue #11 - Two Midnight Census IPPS Payment Reduction to case number 18-0112GC
Issue #10 - Uncompensated Care ("UCC") Distribution Pool to case number 18-0113GC

As stated above, the subject individual appeal, case number 17-1744, was dismissed and is no longer actively pending before the Board. An issue cannot be transferred from an appeal that is closed. The requests to transfer the above referenced issues to the CIRP groups identified above are hereby **denied.**

Board Members:

L. Sue Andersen, Esq.
Charlotte F. Benson, C.P.A.
Gregory H. Ziegler

FOR THE BOARD:



L. Sue Andersen, Esq.
Chairperson

cc: Wisconsin Physicians Service
Byron Lamprecht
Cost Report Appeals
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James C. Ravindran
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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MAR 07 2018

CERTIFIED MAIL

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

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

RE: Ozarks Medical Center
Provider No. 26-0078
FYE 12/31/2006
PRRB Case No. 13-1733

Dear Mr. Ravindran 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:

Ozarks Medical Center, the Provider, appealed a Revised Notice of Program Reimbursement (RNPR) for the 12/31/2006 cost reporting period. Ozarks Medical Center is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in a Revised Notice of Program Reimbursement ("NPR") dated October 25, 2012.

The Provider filed the appeal April 23, 2013, with the following issues:

1) Issue No. 1 is entitled "Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)" (hereinafter "DSH/SSI Percentage (Provider Specific);
2) Issue No. 2 is entitled "Disproportionate Share Hospital ('DSH')/Supplemental Security Income ('SSI") (Systemic Errors)" (hereinafter "DSH/SSI Systemic Errors");
3) Issue No. 3 is entitled "Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days";
4) Issue No. 4 is entitled "Disproportionate Share Hospital Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)";

5) Issue No. 5 is entitled "Disproportionate Share Hospital Payment – Exclusion of Part C Days from Denominator of Medicare Percentage".

On July 15, 2013, the Board received a request to transfer various issues to group appeals including the SSI Systemic Errors issue to case no. 13-1439G.

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

Medicare Contractor's Contentions:

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 that the Provider transferred to case no. 13-1439G in violation of PRRB Rule 4.5.

Furthermore, the Medicare Contractor argues that there is no final determination with respect to the provider's subsidiary appeal" of the SSI Realignment. Finally, the Medicare Contractor notes that the Provider has appealed from a revised NPR and argues that there was no adjustment related to SSI realignment, as required by C.F.R § 405.1889.

Provider's Contentions:

The Provider contends that the Medicare Contractor is incorrect when arguing that the DSH/SSI realignment issue is not an appealable issue.[1] The Provider states that the Provider is addressing not only a realignment of the SSI percentage but also addressing various errors of omission and commission that do not fit into the "systemic errors" category.[2] 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 2006 as a result of its understated SSI percentage.[3]

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).[4] The decision here that was abandoned was that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS.[5] The Provider reasons that it has specifically identified patients believed to be entitled to Medicare Part A and SSI who were not included in the SSI percentage due to errors that may be specific to the Provider, but are not the systemic errors identified in the *Baystate* litigation.[6]

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[1] *See* Provider's March 1, 2018 Jurisdictional Response at 2.
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*

Board's Decision:

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

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

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was transferred to a group and is dismissed by the Board.[7] 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."[8] The Provider's legal basis for Issue No. 1 also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[9] 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."[10]

The Provider's Systemic Errors issue is "[whether] the Secretary properly calculated the Provider's Disproportionate Share Hospital/Supplemental Security Income percentage."[11] Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has filed directly into a group appeal.

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

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

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[7] *See* Provider's Individual Appeal Request at Tab 3.
[8] *Id.* at Tab 3, Issue 1.
[9] *Id.*
[10] *Id.*
[11] *Id.* at Tab 3, Issue 2.

Conclusion:

It should be noted that the SSI Provider Specific issue in the Provider's final position papers is somewhat different from the issue statements in its appeal requests. The final position paper reads:

> The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

The Provider then goes on to discuss the case *Loma Linda Community Hosp. v. Dept. of Health and Human Services.* and the fact that it is still waiting for its MedPAR data to analyze. This issue statement focuses less on the Provider requesting realignment, but is still duplicative of the Systemic Errors issue that the Provider has transferred to various CIRP Groups.

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue in case no. 13-1733 for Ozarks Medical Center.

PRRB Case No. 13-1733 is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

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

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAR 07 2018

CERTIFIED MAIL

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

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

RE: Ozarks Medical Center
Provider No. 26-0078
FYE 12/31/2011
PRRB Case No. 15-2779

Dear Mr. Ravindran 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:

Ozarks Medical Center, the Provider, appealed an Original Notice of Program Reimbursement ("NPR") dated December 17, 2014, for the 12/31/2011 cost reporting period. The Provider filed the appeal with the following issues in its June 18, 2015 appeal request:

1) Issue No. 1 is entitled "Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)" (hereinafter "DSH/SSI Percentage (Provider Specific);
2) Issue No. 2 is entitled "Disproportionate Share Hospital ('DSH')/Supplemental Security Income ('SSI") (Systemic Errors)" (hereinafter "DSH/SSI Systemic Errors");
3) Issue No. 3 is entitled "Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days;"
4) Issue No. 4 is entitled "Disproportionate Share Hospital Payment– SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days and No-Pay Part A Days);
5) Issue No. 5 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Days;"

6) Issue No. 6 is entitled "Disproportionate Share Hospital Payment – Medicaid Fraction/Medicare Managed Care Part C Days;
7) Issue No. 7 is entitled "Disproportionate Share Hospital Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days);"
8) Issue No. 8 is entitled "Disproportionate Share Hospital Payment – Outlier Payments (Fixed Loss Threshold)."

On February 24, 2016, the Board received a request to transfer various issues to group appeals, including the SSI Systemic Errors issue to case no. 15-3037G.

The Provider withdrew Issue No. 5, Medicaid Eligible Days.

There is one issue that remained in the appeal: SSI Provider Specific, which is relevant to the jurisdictional challenge pending in the appeal.

Medicare Contractor's Contentions:

The Medicare Contractor filed a jurisdictional challenge over four issues in the appeal: the SSI Provider Specific; SSI Systemic Errors; Medicare Managed Care Part C; and dual eligible days issues. The Medicare Contractor identified the Medicare Managed Care Part C and Dual Eligible days issues as duplicate issues, because the Provider also appealed those issues in both the Medicare and Medicaid fractions. Because the Provider transferred the SSI Systemic Errors; Part C Days' and Dual Eligible Days issues to group appeals, the Board will not address these jurisdictional challenges.

SSI Provider Specific

The Medicare Contractor argued that the Board does not have jurisdiction over this issue because a realignment, a change in the computation from the federal fiscal year to the hospital's fiscal year, is a provider election, not a Medicare Contractor final determination.[1] The Medicare Contractor concluded that because a realignment is not a final determination, the Board does not have jurisdiction over the issue pursuant to 42 C.F.R. § 405.1803.

Provider's Contentions:

The Provider argued that the Board has jurisdiction over both the SSI Provider Specific issue and the SSI Systemic Errors issue because they are distinct issues and the realignment issue is an appealable issue. The Provider argued that it is not only addressing a realignment of the SSI percentage, but also addressing "various errors of omission and commission that do not fit into the "systemic errors" category."[2]

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[1] Medicare Contractor Jurisdictional Challenge at 4.
[2] Provider's Jurisdictional Response at 2.

Board's Decision:

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

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

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that was transferred to a group and should be dismissed by the Board.[3] 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."[4] The Provider's legal basis for Issue No. 1 also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[5] 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."[6]

The Provider's Systemic Errors issue is "[whether] the Secretary properly calculated the Provider's Disproportionate Share Hospital/Supplemental Security Income percentage."[7] Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has filed directly into a group appeal.

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

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

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

Conclusion:

It should be noted that the SSI Provider Specific issue in the Provider's final position papers is somewhat different from the issue statements in its appeal requests. The final position paper reads:

> The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

The Provider then goes on to discuss the case *Loma Linda Community Hosp. v. Dept. of Health and Human Services.* and the fact that it is still waiting for its MedPAR data to analyze. This issue statement focuses less on the Provider requesting realignment, but is still duplicative of the Systemic Errors issue that the Provider has transferred to various CIRP Groups.

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue in case no. 15-2779 for Ozarks Medical Center.

PRRB Case No. 15-2779 is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

Charlotte Benson for

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

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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MAR 12 2018

Cynthia F. Wisner, Esq.
Associate Counsel
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RE: **Expedited Judicial Review Determination**
14-3578GC Trinity Health 2011 DSH Medicaid Advantage Group
14-3676GC Trinity Health 2011 DSH SSI Medicare Advantage Group

Dear Ms. Wisner:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 23, 2018 request for expedited judicial review (EJR) (received February 26, 2018) for the above-referenced appeals. The decision of the Board is set forth below.

Issue in Dispute

> Whether Medicare Advantage Days (Part C Days) should be removed from the disproportionate share hospital adjustment (DSH adjustment) Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Selelius*[1]. . . and *Allina Health Services v. Price*[2] . . . (The "Part C Days Issue").[3]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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[1] 746 F. 3d 1102 (D.C. Cir. 2014).
[2] 863 F. 3d 937 (D.C. Cir. 2017).
[3] Providers' EJR Request at 1.
[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

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

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

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

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

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

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

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

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. §

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[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] 42 C.F.R. § 412.106(b)(4).

1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

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

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

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

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

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

> . . . 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*

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

> *included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[18]

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

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20] (emphasis added)

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[22] vacated the FFY 2005 IPPS rule. In *Allina Health Services v. Price,* the D.C. Circuit Court concluded that the Secretary was required to engage in notice and comment rule making before deciding to include Part C days in the Medicare fraction and, consequently, the Medicare fractions were procedurally invalid.[23]

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[18] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[19] 69 Fed. Reg. at 49,099.
[20] *Id.*
[21] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] *Allina Health Services v. Price* at 943-44.

Providers' Request for EJR

The Providers point out that because the Secretary has not acquiesced to the decision[s] in *Allina*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (the 2004 Rule). The Providers state that the Board has jurisdiction over the appeals and there are no facts in dispute. The Providers note that the Board is bound by the 2004 Rule and does not have the authority to grant the relief sought, and, as a result, the Board should grant EJR.

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2011.

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

In both case number 14-3578GC and 14-3576GC, #3 Saint Anne's Hospital (provider number 36-0012) and # 9 St. Joseph Mercy Hospital (provider number 23-0029) identified adjustments 11 and 5, respectively, as the subject of their appeals. These adjustments removed protested amounts from the cost reports. The regulation, 42 C.F.R. § 405.1835(a)(1)(ii), requires for cost report periods on or after December 31, 2008, that providers that seek reimbursement for costs that are not allowable, file its cost report following the applicable procedures for protest. The Provider Reimbursement Manual (CMS Pub. 15-2) § 4030.1 requires the provider to enter the protest amount on Line 75 of Worksheet E, Part A and attach a schedule showing the details of the protested amounts and the computations. The Board's Rule 21.D. requires that the Provider place the details of the protested amount under the audit adjustment report page containing the adjustment for the protested amount to establish that the Provider was seeking additional reimbursement for Medicare Part C Days. These Providers did not furnish this information, consequently, the Board cannot determine if the Provider protested the Medicare Part C reimbursement which is necessary to establish jurisdiction over the Providers. Since #3 Saint Anne's Hospital (provider number 36-0012) and # 9 St. Joseph Mercy Hospital (provider number 23-0029) did not establish that the Board has jurisdiction over the Medicare Part C Days issue, the Board hereby dismisses the Providers from the appeal. Since jurisdiction over a provider is a prerequisite to granting a request for EJR, the Providers' request for EJR is hereby denied.

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

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

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request involve fiscal year 2011, thus the appealed cost reporting period fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request. [26]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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[25] *See* 42 C.F.R. § 405.1837.

[26] On February 27, 2018, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in these cases. 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.

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

Board Members Participating

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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MAR 12 2018

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Noridian Healthcare Solutions
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P.O. Box 6782
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RE: El Camino Hospital
Provider No.: 05-0308
FYE: 6/30/13
PRRB Case No.: 16-1229

Dear Ms. Ponce and Ms. Frewert,

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

Background

The Provider submitted a request for hearing on March 9, 2016, based on a Notice of Program Reimbursement ("NPR") dated September 16, 2015. The hearing request included fifteen issues. Thirteen issues were subsequently transferred to group appeals via requests submitted on various dates. One issue was withdrawn. The sole remaining issue in the appeal is Issue No. 15 – Medicare Disproportionate Share Hospital (DSH) – SSI Realignment. The Board reviewed jurisdiction over this issue on its own motion.

Board's Decision

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

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

federal fiscal year to its cost reporting year, as was the case here, 42 C.F.R. § 412.106(b)(3) makes clear that the Provider must use the data from its cost reporting year; there is no appeal right that stems from a realignment request.

As the SSI Realignment issue was the last issue remaining in the appeal, the Board hereby closes the appeal and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

FOR THE BOARD

Charlotte F. Benson for

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

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

cc: Federal Specialized Services
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MAR 13 2018

CERTIFIED MAIL

Corinna Goron, President
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RE: UH Geauga Medical Center, 36-0192, 12/31/2013, CN, 16-1308
UH Regional Hospital, 36-0075, 12/31/2013, CN 16-1586
Robinson Memorial Hospital, 36-0078, 12/31/2013, CN 17-0288

Dear Ms. Goron:

Each of the Providers listed above appealed from a Notice of Program Reimbursement (NPR) for a 2013 cost reporting period. Each NPR was issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). Each of the NPRs were issued between September 2015 and April 2016.

For each Provider the only remaining issue in the individual appeal is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)*. All of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Systemic Errors)* issue directly into 16-1321GC, the HRS UHHS 2013 DSH SSI Percentage CIRP Group.

Board's Decision

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

Although the Medicare Contractor did not challenge jurisdiction over this issue, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue for any of the above-referenced Providers. The jurisdictional analysis for the SSI Provider Specific issue has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the

Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of the issue – the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage – is duplicative of the Systemic Errors issue that was directly added to case no. 16-1321GC and is hereby dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Providers' legal basis for the SSI Provider Specific issue also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[3] The Providers argue that the "SSI percentage published by [CMS] was incorrectly computed . . . ." and ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors issue as stated in the group appeal request for case no. 16-1321GC is:

> . . . the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare Statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services (CMS) and used by the Lead MAC to settle their Cost Report does not address all deficiencies described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.

Thus, the Providers' disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage as stated in the Provider specific issue statement is duplicative of the Systemic Errors issue that has been filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Providers at issue here are Common Issue Related Party ("CIRP") Providers, they are required by regulation to pursue the common issue in a group appeal.[5] Because each of the above-referenced Providers directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

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[1] *See* Providers' Individual Appeal Requests at Tab 3 and Appeal Request in 16-3121GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*
[5] 42 C.F.R. § 405.1837(b)(1)(i).

The second aspect of the Provider Specific issue – the Providers preserving their 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 for appeal purposes. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Providers' issue statements.

Conclusion

The only remaining issue in these appeals is the SSI Provider Specific issue and the Board finds that it does not have jurisdiction over this issue for the three above-referenced Providers. The Board finds that the Providers' challenges to the DSH SSI regulation and statute are properly pending in a CIRP Group. With respect to the potential requests for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced appeals. PRRB Case Nos. 16-1308; 16-1586 and 17-0288 are hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

Charlotte Benson for

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

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

cc: Judith E. Cummings, CGS Administrators
Wilson Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
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MAR 13 2018

CERTIFIED MAIL

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

RE: UH Richmond Medical Center, 36-0075, 12/31/2011, CN, 15-2344
UHHS Bedford Medical Center, 36-0115, 12/31/2011, CN, 15-2346
EMH Regional Medical Center, 36-0145, 12/31/2011, CN, 15-2183

Dear Ms. Goron:

Each of the Providers listed above appealed from a Notice of Program Reimbursement (NPR) for a 2011 cost reporting period. Each NPR was issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). Each of the NPRs was issued in October 2014.

For each Provider the only remaining issue in the individual appeal is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)*. All of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Systemic Errors)* issue directly into 15-2185GC, the HRS UHHS 2011 DSH/SSI Percentage CIRP Group.

Board's Decision

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

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

The first aspect of the issue – the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage – is duplicative of the Systemic Errors issue that was directly added to case no. 15-2185GC and is hereby dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Providers' legal basis for the SSI Provider Specific issue also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[3] The Providers argue that the "SSI percentage published by [CMS] was incorrectly computed . . . ." and ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors issue as stated in the group appeal request for case no. 15-2185GC is:

> . . . the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare Statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services (CMS) and used by the Lead MAC to settle their Cost Report does not address all deficiencies described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.

Thus, the Providers' disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage as stated in the Provider specific issue statement is duplicative of the Systemic Errors issue that has been filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Providers at issue here are Common Issue Related Party ("CIRP") Providers, they are required by regulation to pursue the common issue in a group appeal.[5] Because each of the above-referenced Providers directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

The second aspect of the Provider Specific issue – the Providers preserving their right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period – is

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[1] *See* Providers' Individual Appeal Requests at Tab 3 and Appeal Request in 15-2185GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*
[5] 42 C.F.R. § 405.1837(b)(1)(i).

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 for appeal purposes. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Providers' issue statements.

Conclusion

The only remaining issue in these appeals is the SSI Provider Specific issue and the Board finds that it does not have jurisdiction over this issue for the above-referenced Providers. The Board finds that the Providers' challenges to the DSH SSI regulation and statute are properly pending in a CIRP Group. With respect to the potential requests for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced appeals. PRRB Case Nos. 15-2344; 15-2346 and 15-2183 are hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

Charlotte Benson for
Gregory H. Ziegler, CPA, CPC-A
Board Member

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

cc: Judith E. Cummings, CGS Administrators (J-15)
Wilson Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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MAR 13 2018

CERTIFIED MAIL

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

RE: Encino Hospital Medical Center, 05-0158, 12/31/2011, CN, 17-0589
Desert Valley Hospital, 05-0709, 12/31/2011, CN 15-2945
San Dimas Community Hospital, 05-0588, 12/31/2011, CN 15-2793
Paradise Valley Hospital, 05-0024, 12/31/2011, CN 15-2752
Chino Valley Medical Center, 05-0586, 12/31/2011, CN, 15-2746
West Anaheim, 05-0426, 12/31/2011, CN 15-2466
Lower Bucks Hospital, 39-0070, 06/30/2011, CN 15-0057
Knapp Medical Center, 45-0128, 06/30/2011, CN 15-0006

Dear Ms. Goron:

Each of the Providers listed above appealed from a Notice of Program Reimbursement (NPR) for a 2011 cost reporting period. Each NPR was issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). Each of the NPRs were issued between April 2014 and June 2016.

For each Provider the only remaining issue in the individual appeal is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)*. All of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Systemic Errors)* issue directly into 15-0001GC, the HRS Prime 2011 DSH/SSI Percentage CIRP Group.

Board's Decision

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

Although the Medicare Contractor only challenged jurisdiction over this issue in case number 15-0006, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue for any of the above-referenced Providers. The jurisdictional analysis for the SSI Provider

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

The first aspect of the issue – the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage – is duplicative of the Systemic Errors issue that was directly added to case no. 14-2928GC and is hereby dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Providers' legal basis for the SSI Provider Specific issue also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[3] The Providers argue that the "SSI percentage published by [CMS] was incorrectly computed . . . ." and ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors issue as stated in the group appeal request for case no. 15-0001GC is:

> . . . the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare Statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services (CMS) and used by the Lead MAC to settle their Cost Report does not address all deficiencies described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.

Thus, the Providers' disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage as stated in the Provider specific issue statement is duplicative of the Systemic Errors issue that has been filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Providers at issue here are Common Issue Related Party ("CIRP") Providers, they are required by regulation to pursue the common issue in a group appeal.[5] Because each of the above-referenced Providers directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors

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[1] *See* Providers' Individual Appeal Requests at Tab 3 and Appeal Request in 15-0001GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*
[5] 42 C.F.R. § 405.1837(b)(1)(i).

issue.

The second aspect of the Provider Specific issue – the Providers preserving their 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 for appeal purposes. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Providers' issue statements.

Conclusion

The only remaining issue in these appeals is the SSI Provider Specific issue and the Board finds that it does not have jurisdiction over this issue for the above-referenced Providers. The Board finds that the Providers' challenges to the DSH SSI regulation and statute are properly pending in a CIRP Group. With respect to the potential requests for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced appeals. PRRB Case Nos. 17-0589; 15-2945, 15-2793, 15-2752, 15-2746, 15-2466, 15-0057 and 15-0006 are hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAR 15 2018

CERTIFIED MAIL

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

RE: Centinela Hospital Medical Center, 05-0739, 12/31/2010, CN 16-1917
Paradise Valley Hospital, 05-0024, 12/31/2010, CN 16-1350
Encino Hospital Medical Center, 05-0158, 12/31/2010, CN, 15-2531
Chino Valley Medical Center, 05-0586, 12/31/2010, CN, 15-1357
Alvarado Hospital Medical Center, 05-0757, 12/31/2010, CN, 15-1123
Montclair Hospital Medical Center, 05-0758, 12/31/2010, CN, 15-0473
Shasta Regional Medical Center, 05-0764, 12/31/2010, CN 15-0378
Sherman Oaks Hospital, 05-0755, 12/31/2010, CN 14-3670
Garden Grove Medical Center, 05-0230, 12/31/2010, CN 14-3181
San Dimas Community Hospital, 05-0588, 12/31/2010, CN 14-3071

Dear Ms. Goron:

Each of the Providers listed above appealed from a Notice of Program Reimbursement (NPR) for a 2010 cost reporting period. Each NPR was issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). Each of the NPRs were issued between October 2013 and February 2016.

For each Provider the only remaining issue in the individual appeal is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)*. All of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Systemic Errors)* issue directly into 14-2928GC, the HRS Prime 2010 DSH/SSI Percentage (Systemic Errors) CIRP Group.

Board's Decision

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

Although the Medicare Contractor only challenged jurisdiction over this issue in 2 of the cases (14-3670 & 14-3181), the Board finds that it does not have jurisdiction over the SSI Provider Specific issue for any of the above-referenced Providers. The jurisdictional analysis for the SSI Provider Specific issue has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of the issue – the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage – is duplicative of the Systemic Errors issue that was directly added to case no. 14-2928GC and is hereby dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Providers' legal basis for the SSI Provider Specific issue also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[3] The Providers argue that the "SSI percentage published by [CMS] was incorrectly computed . . . ." and ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors issue as stated in the group appeal request for case no. 14-2928GC is:

> . . . the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare Statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services (CMS) and used by the Lead MAC to settle their Cost Report does not address all deficiencies described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.

Thus, the Providers' disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage as stated in the Provider specific issue statement is duplicative of the Systemic Errors issue that has been filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Providers at issue here are Common Issue Related Party ("CIRP") Providers, they are required by regulation to pursue the

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[1] *See* Providers' Individual Appeal Requests at Tab 3 and Appeal Request in 14-2928GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*

common issue in a group appeal.[5] Because each of the above-referenced Providers directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

The second aspect of the Provider Specific issue – the Providers preserving their 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 for appeal purposes. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Providers' issue statements.

Conclusion

The only remaining issue in these appeals is the SSI Provider Specific issue and the Board finds that it does not have jurisdiction over this issue for the above-referenced Providers. The Board finds that the Providers' challenges to the DSH SSI regulation and statute are properly pending in a CIRP Group. With respect to the potential requests for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced appeals. PRRB Case Nos. 16-1917; 16-1350, 15-2531, 15-1357, 15-1123, 15-0473, 15-0378, 14-3670, 14-3181 and 14-3071 are hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

Charlotte Benson for

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

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

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

[5] 42 C.F.R. § 405.1837(b)(1)(i).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
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MAR 14 2018

Certified Mail

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

RE: *HRS ProMedica Health System FFY 2017 Two Midnight CIRP Group*
HRS UHHS FFY 2017 Two Midnight CIRP Group
HRS Lafayette General Health FFY 2017 Two Midnight CIRP Group
Provider Nos.: Various
FYEs: 9/30/2017
PRRB Case Nos.: 17-1159GC, 17-0941GC and 17-1010GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the above referenced Providers' February 9, 2018 Revised Request for Expedited Judicial Review (EJR) (received February 13, 2018) and the Providers' January 18, 2018 (case numbers 17-1159GC and 17-0941GC) and January 15, 2018 (case number 17-1010GC) Jurisdictional Response (received January 23, 2018) to Federal Specialized Services' (FSS) January 2, 2018 (case numbers 17-1159G and 17-0941G) and December 17, 2017 (case number 17-1010GC) Jurisdictional Challenge. The Board's decision is set forth below.

Issue under Dispute

Whether the .06 positive adjustment in the fiscal year (FY) 2017 Inpatient Prospective Payment System (IPPS) final rule is invalid for being arbitrary and capricious and promulgated in a procedurally deficient way. [1]

Statutory and Regulatory Background

In the final IPPS rule for federal fiscal year (FFY) 2014[2], the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) Rule[3] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving

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[1] Providers' January 15, 2018 (case no. 17-1010GC) and January 18, 2018 (case nos. 17-1159GC and 17-0941GC) Jurisdictional Response at 1. In the Board's January 12, 2018 EJR denial decision for the above referenced appeals the Board found the Providers had failed to demonstrate in their EJR Request, dated December 18, 2017, what they were challenging in regards to the FY 2017 final rule. In their Jurisdictional Response the above referenced providers clarified what they were challenging in regards to the FY 2017 final rule.

[2] 78 Fed. Reg. 50,496 (August 19, 2013).

[3] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).

observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

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

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

Medicare Part A

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

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[4] 78 Fed. Reg. at 50,907.
[5] *Id.*
[6] *Id.*
[7] CMS Pub. 100-02, Chapter 6, § 20.6 and Chapter 1, § 10.
[8] 78 Fed. Reg. at 50,907-08.

In the FFY 2014 IPPS proposed rule,[9] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2 midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[10]

Medicare Part B

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

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

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[9] *See generally* 78 Fed. Reg. 27,486, 27,645-46 (May 10, 2013).
[10] 78 Fed. Reg. at 50,908.
[11] *Id.*
[12] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/index.html.
[13] 78 Fed. Reg. at 50,909.
[14] *Id.* at 50,927.

The 2-Midnight Rule

In the final IPPS rule for FFY 2014, the Secretary pointed out that CMS had established policy that recognized there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

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

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

The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2 midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2 midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[18] The Secretary made the same 0.2 percent reduction to capital IPPS

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

rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[19] In the final IPPS rules for 2015 and 2016, the Secretary did not reverse the 0.2 percent reduction to the standardized amount made in 2014, and, therefore, continued to apply the contested reduction for the FFY 2015 and 2016 period.[20]

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

Providers' EJR Request and Jurisdictional Response

The Providers contend that in the FY 2014 IPPS final rule, CMS instituted its 2 midnight policy. CMS estimates that its 2 midnight policy would increase IPPS operating and capital expenditures by approximately $220 million. However, the Providers argue hospitals will not receive any of this increase because CMS invoked its authority in sections 1886(d)(5)(I)(1) and 1886(g) of the Social Security Act (the Act) to offset this amount by applying a 0.2 percent reduction adjustment to the operating IPPS standardized amount, the hospital specific rates and the Puerto Rico specific standardized amount and a 0.2 adjustment reduction for capital IPPS expenditures.

The Providers maintain the decision to impose a $220 million payment cut is arbitrary and capricious because it relies on faulty assumptions, improperly excluded relevant data and is not adequately explained. The Providers assert the FY 2014 final rule states that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, causing a net gain of 40,000 inpatient stays. The Providers contend the final rule does not give much detail as to how CMS arrived at its estimate of a net gain of 40,000 inpatient stays; the rule does not explain the number of claims that were examined or how the data was used.[22]

The Providers argue CMS assumes that hospitals will always bill stays lasting at least 2 midnights as inpatient claims, claims for stays lasting at least 2 midnights will always be paid as inpatient, hospitals will always bill stays lasting less than 2 midnights as outpatient claims and claims for stays lasting less than 2 midnights will always be paid as outpatient. The Providers do not believe that these assumptions are valid, especially in light of the Part B inpatient policy. The Providers maintain the Part B policy, finalized in the 2015 IPPS final rule, provides that if a hospital bills a hospital encounter as an inpatient stay and a Recovery Auditor (RAC) or other Medicare contractor subsequently determines that the inpatient stay was not reasonable and necessary and the beneficiary should have been treated on an outpatient basis instead, the hospital may re-bill for the services under Part B, but must do so within 12 months of the date of service.

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[19] *Id.* at 50,990.
[20] 79 Fed. Reg. 49,854, 50,011 (Aug. 22, 2014) and 80 Fed. Reg. 49,325, 49,593, 49,686 (Aug. 17, 2015).
[21] 81 Fed. Reg. 56762, 57059-60 (August 22, 2016).
[22] Providers' February 9, 2018 Revised EJR Request at 6-7.

The Providers contend it may not be true that hospitals will always bill as inpatient for stays spanning at least 2 midnights, and it may not be true that Medicare will pay under Part A for all such stays. Hospitals may be concerned that short stays, including stays spanning 2 midnights, will be denied under Part A and that they will be unable to re-bill under Part B in the 12-month window, so they may bill some of these stays under Part B to begin with. Also, the hospital may decide not to bill under Part A, despite having admitted the patient, because it may believe that the medical record does not contain sufficient documentation to explain why the ordering physician had a reasonable explanation that the beneficiary was expected to cross 2 midnights.[23]

The Providers maintain where Part A payment is allowed, it would increase the total amount of Part A payment, despite the 2 midnight policy, but if Part A payment is denied, not only would the total amount of Part A payment not increase, but there likely would not be Part B payment to effect a partial offset of the total amount of Part A payment because the hospitals likely will be unable to re-bill under Part B. The Providers assert the final rule indicates that in arriving at its estimate, CMS did not consider medical cases but instead claims containing medical MS-DRGs were excluded. The Providers argue the FY 2014 IPPS final rule is procedurally invalid for failing to have notified commenters that medical MS-DRGs were being excluded from the analysis of to what extent outpatient cases would shift to inpatient and vice versa and is also substantively invalid because it makes no sense to have excluded the medical MS-DRGs. The Providers contend on December 1, 2015, the Secretary published a notice in the Federal Register with an opportunity for comment.[24] The Providers argue CMS' explanation in the December 1, 2015 notice as to why it did not consider medical cases when estimating a net increase in 40,000 inpatient cases is flawed and unconvincing.[25] The Providers assert CMS has not adequately explained why it considered only surgical cases and excluded from consideration medical cases when concluding that there would be a net shift in inpatient cases. [26]

The Providers contend the decision to impose a $220 million payment cut is arbitrary and capricious because it does not adequately take into account the payment reduction made by the Part B inpatient policy. The Providers argue even if the 2 midnight policy does result in increased Medicare payments in the vicinity of $220 million per year, CMS projects that the closely related inpatient Part B policy reduces Medicare payments by almost a billion dollars a year, yet there is no increase in the payment rates to take into account the reduced payments.[27] The Providers maintain the decision to impose a $220 million payment cut is arbitrary and capricious because it does not provide any mechanism for making adjustments to, or reversing the effects of, the payment cut if CMS' estimate is incorrect. The Providers assert that the estimate of additional $220 million IPPS expenditures is highly speculative at best. CMS itself acknowledges that its estimate is subject to a variety of factors. The Providers contend the estimates are sensitive to the assumed utilization changes in inpatient and outpatient utilization. Yet there is no provision for reversing the effects of an inaccurate increase in IPPS payments.[28]

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[23] *Id.* at 8-9.
[24] 80 Fed. Reg. 75107.
[25] Providers' February 9, 2018 Revised EJR Request at 10-11.
[26] *Id.* at 11-12.
[27] *Id.* at 12.
[28] *Id.* at 15.

The Providers maintain the decision to imposes a $220 million payment cut is otherwise not in accordance with law because CMS did not have statutory authority to impose an across the board payment reduction. The Providers maintain the authority relied upon by CMS, its exceptions and adjustments authority, under section 1886(d) and 1886(g) of the Social Security Act does not permit CMS to make across the board decreases in payment rates due to hospitals. The Providers argue the exceptions and adjustments clause permits CMS to make payment adjustments only to specific hospitals or specific types of hospitals rather than payment adjustments to all hospitals.[29]

The Providers maintain that the FY 2016 IPPS final rule[30] as published in the Federal Register is a final determination. The payment reduction, which is a continuation of the reduction in the standardized amount that was first announced in the FY 2014 IPPS final rule, is a final determination for the purposes of Board jurisdiction. The Providers argue the court in *Washington Hospital Center v. Bowen*[31], ruled that providers could challenge PPS payments without having to wait for the completion of a cost year and/or subsequent issuance of a Notice of Program Reimbursement, rendering final rules setting PPS rates final determinations for the purpose of Board jurisdiction.[32]

The Providers contend in the FY 2017 IPPS proposed rule, CMS stated that it believes it is appropriate to abandon the 0.2 percent payment reduction. It proposed to increase the payment rates prospectively, beginning in FY 2017, by 0.2 percent, as well as to make a one-time positive adjustment of 0.6 percent in order to reverse the effects of the 0.2 percent payment cut for FYs 2014, 2015 and 2016. CMS finalized the policy it proposed in the FY 2017 IPPS proposed rule. The Providers argue the one time positive adjustment of 0.6 percent will not make the Providers whole for the reduction in their IPPS payments caused by the 0.2 reduction imposed for FYs 2014-2016, and in any case the FY 2014 rule remains in effect.[33] The Providers dispute that CMS has issued a correction to the 0.2 percent payment reduction imposed by the FY 2014 final rule. The Providers disagree that the one-time .06 positive adjustment in the FY 2017 final rule makes the Providers whole for the injury caused by the 0.2 payment reduction imposed by the FY 2014 IPPS final rule for FYs 2014-2016 because the providers argue the number of discharges for FY 2017 likely will not equal the average number of discharges for the period FY 2014-2016 due to the recent trend of declining admissions. The Providers argue 3 x.02 does not equal .06. The Providers maintain for that reason the plaintiffs in *Shands Jacksonville Medical Center, Inc. et al. v. Burwell* [34] continue to litigate the FY 2014 IPPS final rule and argue that they have not been made whole by the FY 2017 final rule.

The Providers contend the Department of Justice (DOJ) has taken the position that the FY 2017 final rule supersedes the FY 2014 IPPS final rule and that any further relief beyond the .06 one-time positive adjustment must be obtained through a successful challenge to the FY 2017 final rule. The Providers argue DOJs position is exactly the opposite of the Medicare Contractor's position in this case. The Providers maintain they are not seeking a total reversal of the .06 positive adjustment through their challenge to the FY 2017 final rule, rather only the shortfall

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[29] *Id.* at 15-16.
[30] 80 Fed. Reg. 29686 (August 17, 2015).
[31] 795 F.2d 139, 141 (D.C. Cir. 1986).
[32] Providers' February 9, 2018 Revised EJR Request at 16-17.
[33] *Id.* at 12.
[34] 139 F.Supp. 3d 240 (D.D.C 2015).

between what they are paid under the .02 positive adjustment and what they should be paid if CMS had simply reversed the effects of the .02 percent payment cut for each of FYs 2014-2016.[35]

The Providers argue the Board does have jurisdiction over the Providers. However, the Board does not have the authority to declare the .02 decrease or the .06 positive adjustment in the IPPS rates invalid. The Providers maintain because the Board is bound to comply with the decrease in IPPS rates, the Board lacks the authority to decide whether the final rule is procedurally invalid, arbitrary, capricious, and outside the statutory authority of CMS. The Providers assert that EJR is therefore appropriate.[36]

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the Requests for Hearing, Revised Request for Expedited Judicial Review and Jurisdictional Response. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). The documentation shows that the estimated amount in controversy for each of the above referenced group appeals exceeds $50,000, as required for a group appeal and the appeals were timely filed from the issuance of the August 22, 2016 Federal Register (FFY 2017 final rule).[37] The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount in each case.

The Board finds that:

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

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

3) it is without the authority to decide the legal question of whether the .06 positive adjustment in the FY 2017 final rule is proper.

Accordingly, the Board finds that the above identified challenge to the FFY 2017 Two Midnight Rule falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' Request for Expedited Judicial Review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these appeals, the Board hereby closes case numbers 17-1159GC, 17-0941GC and 17-1010GC.

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[35] Providers' January 18, 2018 Jurisdictional Response at 2.
[36] *Id.*
[37] *See District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare and Medicaid Guide (CCH)* ¶ 41,025 (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

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

For the Board

L. Sue Andersen, Esq.
Chairperson

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

cc: Judith Cummings, CGS Administrators
Byron Lamprecht, Wisconsin Physician Service
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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MAR 15 2018

Certified Mail

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RE: **Expedited Judicial Review Determination**
15-0419GC Trinity Health 2012 DSH Medicaid Advantage Group
15-0416GC Trinity Health 2012 DSH SSI Medicare Advantage Group

Dear Ms. Wisner:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 28, 2018 request for expedited judicial review (EJR) (received March 2, 2018) for the above-referenced appeals. The decision of the Board is set forth below.

Issue in Dispute

Whether Medicare Advantage Days (Part C Days) should be removed from the disproportionate share hospital adjustment (DSH adjustment) Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Selelius*[1]. . . and *Allina Health Services v. Price*[2] . . . (The "Part C Days Issue").[3]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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[1] 746 F. 3d 1102 (D.C. Cir. 2014).
[2] 863 F. 3d 937 (D.C. Cir. 2017).
[3] Providers' EJR Request at 1.
[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

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

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

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

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

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

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

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

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. §

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[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] 42 C.F.R. § 412.106(b)(4).

1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

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

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

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

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

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

> . . . 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*

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

> *included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[18]

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

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20] (emphasis added)

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[22] vacated the FFY 2005 IPPS rule. In *Allina Health Services v. Price,* the D.C. Circuit Court concluded that the Secretary was required to engage in notice and comment rule making before deciding to include Part C days in the Medicare fraction and, consequently, the Medicare fractions were procedurally invalid.[23]

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[18] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[19] 69 Fed. Reg. at 49,099.
[20] *Id.*
[21] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] *Allina Health Services v. Price* at 943-44.

Providers' Request for EJR

The Providers point out that because the Secretary has not acquiesced to the decision[s] in *Allina*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (the 2004 Rule). The Providers state that the Board has jurisdiction over the appeals and there are no facts in dispute. The Providers note that the Board is bound by the 2004 Rule and does not have the authority to grant the relief sought, and, as a result, the Board should grant EJR.

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2012.

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

In both case numbers 15-0419GC and 15-0416GC, the following Providers appealed their original NPRs and indicated that they had not protested the Part C days issue by identifying an audit adjustment for a protested amount:

3 St. Ann's Hospital
7 St. Joseph Regional Medical Center
8 Mount Carmel West
9 Mercy Medical Center Sioux City
#11 St. Joseph Mercy Hospital
#12 Mercy Medical Center North Iowa
#13 St. Joseph Mercy Hospital Oakland
#14 Mercy Hospital & Medical Center

The regulation, 42 C.F.R. § 405.1835(a)(1)(ii), requires for cost report periods ending on or after December 31, 2008, that providers that seek reimbursement for costs that are not allowable, file its cost report following the applicable procedures for protest. The Provider Reimbursement Manual (CMS Pub. 15-2) § 4030.1 requires the provider to enter the protest amount on Line 75 of Worksheet E, Part A and

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

attach a schedule showing the details of the protested amounts and the computations. The Board's Rule 21.D. requires that the Provider place the details of the protested amount under the audit adjustment report page containing the adjustment for the protested amount to establish that the Provider was seeking additional reimbursement for Medicare Part C Days. These Providers did not furnish this information, consequently, the Board cannot determine if the Provider protested the Medicare Part C reimbursement which is necessary to establish jurisdiction over the Providers. Since the Providers listed above did not establish that the Board has jurisdiction over the Medicare Part C Days issue, the Board hereby dismisses the Providers from the appeal. Since jurisdiction over a provider is a prerequisite to granting a request for EJR, the Providers' request for EJR is hereby denied. *See* 42 C.F.R. § 405.1842(a).

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

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request involve fiscal year 2012, thus the appealed cost reporting period fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.[26]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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[25] *See* 42 C.F.R. § 405.1837.

[26] On March 1, 2018, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in these cases. 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 Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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MAR 16 2016

CERTIFIED MAIL

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

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

RE: Yale New Haven Hospital
Provider No. 07-0022
FYE 09/30/2007
PRRB Case No. 13-2035

Dear Mr. Rosenberg and Ms. VanArsdale,

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

Background:

Yale-New Haven Hospital, the Provider, appealed an original Notice of Program Reimbursement (NPR) dated November 7, 2012, for the 09/30/2007 cost reporting period. The Provider filed the appeal on April 26, 2013, with the following issues:

1) Issue No. 1 is entitled "Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)" (hereinafter "DSH/SSI Percentage (Provider Specific);
2) Issue No. 2 is entitled "Disproportionate Share Hospital ('DSH')/Supplemental Security Income ('SSI") (Systemic Errors)" (hereinafter "DSH/SSI Systemic Errors");
3) Issue No. 3 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Days";
4) Issue No. 4 is entitled "Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days";
5) Issue No. 5 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Labor Room Days";

6) Issue No. 6 is entitled "Disproportionate Share Hospital Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)";
7) Issue No. 7 is entitled "Disproportionate Share Hospital Payment – Medicaid Eligible Patient Days-Connecticut State Administered General Assistance Outlier Payments.

On October 29, 2013, the Board received a request to transfer various issues to group appeals, including the SSI Systemic Errors issue to case no. 13-3904GC.

The Provider withdrew Issue No. 3, Medicaid Eligible Days.

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

Board's Decision:

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

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

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

The Provider's Systemic Errors issue is "[whether] the Secretary properly calculated the Provider's Disproportionate Share Hospital/Supplemental Security Income percentage."[5] Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that was transferred to case no. 13-3904GC.

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[1] *See* Providers Individual Appeal Request at Tab 3.
[2] *Id.* at Tab 3, Issue 1.
[3] *Id.*
[4] *Id.*
[5] *Id.* at Tab 3, Issue 7.

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

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

Conclusion:

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue, which is the last issue pending in the appeal.

PRRB Case No. 13-2035 is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

Charlotte F. Benson, CPA
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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410-786-2671

MAR 19 2018

CERTIFIED MAIL

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

RE: E. A. Conway Medical Center, 19-0011, 06/30/2011, CN, 15-2069
University Medical Center, 19-0006, 06/30/2011, CN 16-2299
Washington St. Tammany Regional Medical Center, 19-0001, 06/30/2011, CN 16-2230
E.A. Conway Medical Center, 05-0024, 12/31/2011, CN 16-2220

Dear Ms. Goron:

Each of the Providers listed above appealed from a Notice of Program Reimbursement (NPR) for a 2011 cost reporting period. Each NPR was issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). Each of the NPRs were issued between October 2014 and February 2016.

For each Provider the only remaining issue in the individual appeal is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)*. All of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Systemic Errors)* issue directly into 14-2991GC, the HRS LSU 2011 DSH/SSI Percentage (Baystate) CIRP Group.

Board's Decision

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

Although the Medicare Contractor only challenged jurisdiction over this issue in case number 15-2069, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue for any of the above-referenced Providers. The jurisdictional analysis for the SSI Provider Specific issue has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of the issue – the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage – is duplicative of the Systemic Errors issue that was directly added to case no. 14-2991GC and is hereby dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Providers' legal basis for the SSI Provider Specific issue also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[3] The Providers argue that the "SSI percentage published by [CMS] was incorrectly computed . . . ." and ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors issue as stated in the group appeal request for case no. 14-2991GC is:

> . . . the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare Statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services (CMS) and used by the Lead MAC to settle their Cost Report does not address all deficiencies described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.

Thus, the Providers' disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage as stated in the Provider specific issue statement is duplicative of the Systemic Errors issue that has been filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Providers at issue here are Common Issue Related Party ("CIRP") Providers, they are required by regulation to pursue the common issue in a group appeal.[5] Because each of the above-referenced Providers directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

The second aspect of the Provider Specific issue – the Providers preserving their right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period – is

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[1] *See* Providers' Individual Appeal Requests at Tab 3 and Appeal Request in 14-2991GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*
[5] 42 C.F.R. § 405.1837(b)(1)(i).

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 for appeal purposes. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Providers' issue statements.

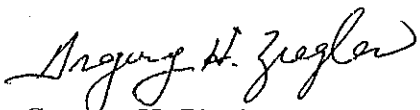
Conclusion

The only remaining issue in these appeals is the SSI Provider Specific issue and the Board finds that it does not have jurisdiction over this issue for the above-referenced Providers. The Board finds that the Providers' challenges to the DSH SSI regulation and statute are properly pending in a CIRP Group. With respect to the potential requests for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced appeals. PRRB Case Nos. 16-2220; 16-2299, 16-2230 and 15-2069 are hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD



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

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

cc: Mounir Kamal, Novitas Solutions, Inc. (J-H)
Wilson Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAR 19 2018

CERTIFIED MAIL

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

RE: University Medical Center, Provider No. 19-0006, FYE 06/30/2012, Case No. 16-2298

Dear Ms. Goron:

The Provider listed above appealed from a Notice of Program Reimbursement (NPR) for a 2012 cost reporting period. The NPR, issued on February 29, 2016, included the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching).

The only remaining issue in the individual appeal is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)*. This Provider also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Systemic Errors)* issue directly into case number 15-0544GC, the HRS LSU 2012 DSH SSI Percentage CIRP Group.

Board's Decision

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

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

The first aspect of the issue – the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage – is duplicative of the Systemic Errors issue that was directly added to case no. 15-0544GC and is

hereby dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Provider's legal basis for the SSI Provider Specific issue also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[3] The Provider argues that the "SSI percentage published by [CMS] was incorrectly computed . . . ." and ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors issue as stated in the group appeal request for case no. 15-0544GC is:

> . . . the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare Statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services (CMS) and used by the Lead MAC to settle their Cost Report does not address all deficiencies described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.

Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage as stated in the Provider specific issue statement is duplicative of the Systemic Errors issue that has been filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Provider at issue here is a Common Issue Related Party ("CIRP") Provider, it is required by regulation to pursue the common issue in a group appeal.[5] Because the above-referenced Provider directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

The second aspect of the 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 for appeal purposes. Based on this

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[1] *See* Providers' Individual Appeal Requests at Tab 3 and Appeal Request in 15-0544GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*
[5] 42 C.F.R. § 405.1837(b)(1)(i).

reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's issue statement.

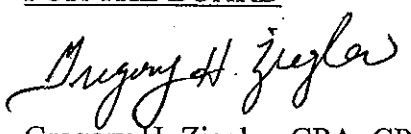
Conclusion

The only remaining issue in this appeal is the SSI Provider Specific issue and the Board finds that it does not have jurisdiction over this issue for the referenced Provider. The Board finds that the Provider's challenges to the DSH SSI regulation and statute are properly pending in a CIRP Group. With respect to the potential request for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced appeal. PRRB Case No. 16-2298 is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD



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

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

cc: Mounir Kamal, Novitas Solutions, Inc. (J-H)
Wilson Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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MAR 1 9 [redacted]

CERTIFIED MAIL

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

RE: Our Lady of the Lake Ascension Community Hospital, Provider No. 19-0242
FYE 06/30/2012, Case No. 15-0662

Dear Ms. Goron:

The Provider listed above appealed from a Notice of Program Reimbursement (NPR) for a 2012 cost reporting period. The NPR, issued on June 13, 2014, included the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching).

The only remaining issue in the individual appeal is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)*. This Provider also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Systemic Errors)* issue directly into case number 15-0670GC, the HRS FMOLHS 2012 DSH SSI Percentage CIRP Group.

Board's Decision

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

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

The first aspect of the issue – the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage – is

duplicative of the Systemic Errors issue that was directly added to case no. 15-0670GC and is hereby dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Provider's legal basis for the SSI Provider Specific issue also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[3] The Provider argues that the "SSI percentage published by [CMS] was incorrectly computed . . . ." and ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[4]

The Providers' Systemic Errors issue as stated in the group appeal request for case no. 15-0670GC is:

> . . . the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare Statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services (CMS) and used by the Lead MAC to settle their Cost Report does not address all deficiencies described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.

Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage as stated in the Provider specific issue statement is duplicative of the Systemic Errors issue that has been filed directly into a group appeal.

The issue of how CMS interpreted its regulation is not an issue that applies "specifically" to one Provider; the issue applies to ALL SSI calculations. Because the Provider at issue here is a Common Issue Related Party ("CIRP") Provider, it is required by regulation to pursue the common issue in a group appeal.[5] Because the above-referenced Provider directly added the Systemic Errors issue to a CIRP group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue.

The second aspect of the 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

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[1] *See* Providers' Individual Appeal Requests at Tab 3 and Appeal Request in 15-0670GC.
[2] *Id.* at Tab 3.
[3] *Id.*
[4] *Id.*
[5] 42 C.F.R. § 405.1837(b)(1)(i).

determination from which the Provider can be dissatisfied for appeal purposes. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's issue statement.

Conclusion

The only remaining issue in this appeal is the SSI Provider Specific issue and the Board finds that it does not have jurisdiction over this issue for the referenced Provider. The Board finds that the Provider's challenges to the DSH SSI regulation and statute are properly pending in a CIRP Group. With respect to the potential request for realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced appeal. PRRB Case No. 15-0662 is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

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

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

cc: Mounir Kamal, Novitas Solutions, Inc. (J-H)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

MAR 20 2018

Certified Mail

Daniel J. Hettich
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1700 Pennsylvania Avenue, NW
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Washington, DC 20006 4706

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

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 15, 2018, requests for expedited judicial review (EJR) (received March 16, 2018) for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> [W]hether CMS unlawfully treats days for which Medicare Part A did not make payment, namely Medicare Advantage days which are paid under Medicare Part C, as days for which patients are entitled to benefits under Medicare Part A for purposes of calculating the Medicare disproportionate share ("DSH") payment.[1]

[1] March 15, 2018 EJR Request at 1.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[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

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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).

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 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 timely filed appeals involving fiscal years 2009 through 2013.

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost reports for the period where the providers seek payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing cost reports under protest.[23] For appeals of RNPRs issued after August 21, 2008, the Board only has jurisdiction to hear a provider's appeal of matters that the Medicare contractor specifically revised within the RNPR.[24] The Board notes that the revised NPR appeals included within this EJR request were issued after August 21, 2008.

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[21] 69 Fed. Reg. at 49,099.
[22] *Allina* at 1109.
[23] *See* 42 C.F.R. § 405.1835(a)(1) (2008).
[24] *See* 42 C.F.R. § 405.1889(b)(1) (2008).

Case Nos. 15-0206G and 15-0208G
(#8) Dubois Regional Medical Center (39-0086), FYE 6/30/2010

This Provider simultaneously filed a timely appeal of its original August 15, 2013 NPR and its October 17, 2013 revised NPR. The adjustment from the revised NPR, that is the subject of the appeals, is Adjustment 4 which adjusted allowable DSH. The revised NPR did not specifically adjust the Medicare Part C issue as required for Board jurisdiction under 42 C.F.R. § 405.1889(b)(1). Therefore, the Board finds that it lacks jurisdiction over this Provider and dismisses the Provider from case numbers 15-0206G and 15-0208G. Since jurisdiction over a Provider's appeal is a prerequisite to granting a request for EJR, the Board hereby denies the request for EJR for Dubois Regional Medical Center's revised NPR appeal. *See* 42 C.F.R. §§ 405.1842 (a),(b)(1) and (f)(1)(i).

The Board has determined the remaining participants involved with the instant EJR requests have appealed from original NPRs that had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy for each group exceeds the $50,000 threshold as required for jurisdiction[25]. 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 are for fiscal years 2009-2013, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time periods at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed,* No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

[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 years and that the participants in these group appeals are entitled to a hearing before the Board;

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the providers' requests for EJR for the issue and the subject years. The providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these groups, the Board hereby closes case numbers 14-3377G, 14-3378G, 15-0206G, 15-0208G, 15-0342G, 15-0343G, 15-2267G, 15-2269G, 15-3365G, 15-3369G, 16-2406G and 16-2407G.

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

FOR THE BOARD:

Gregory H. Ziegler for

L. Sue Andersen, Esq.
Chairperson

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

cc: **(Certified Mail w/Schedules of Providers)**
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MAR 22 2018

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RE: Jurisdiction Decision
Ozarks Medical Center
Provider. No. 26-0078
FYE 12/31/2010
PRRB Case No. 14-3848

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background

On January 27, 2014, the Provider, Ozarks Medical Center, was issued an original Notice of Program Reimbursement ("NPR") for fiscal year end ("FYE") 12/31/2010. The Provider filed its appeal request with the Board on July 28, 2014, in which it appealed nine issues, including the SSI Provider Specific, SSI Systemic Errors, and Medicaid eligible days issues.

On August 19, 2014, the Board received the Medicare Contractor's Jurisdictional Challenge over several issues: SSI realignment; Medicaid eligible days; Medicare Part C days in the Medicaid Fraction; Medicaid Labor and Delivery Days; Dual eligible days in the Medicaid fraction; and Outlier Payments – Fixed Loss Threshold. The Provider responded to the Jurisdictional Challenge on September 18, 2014.

The Provider later requested to transfer various issues to group appeals, including the SSI Systemic Errors issue to case no. 14-1815G. The Provider also withdrew the Labor and Delivery Room Days issue. In its Final Position Paper, the Provider indicated that the only issues remaining in the appeal were the SSI Provider Specific and Medicaid eligible days issues.

Medicare Contractor's Contentions

SSI Provider Specific[1]

The Medicare Contractor argues that the Board does not have jurisdiction over the SSI Realignment issue because it is an issue that is suitable for reopening, but it is not an appealable issue. 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.

Medicaid Eligible Days

The Medicare Contractor argues that the Board does not have jurisdiction over the Medicaid Eligible Days issue because the Provider failed to identify any adjustment to Medicaid days with which it could be dissatisfied. The Provider is dissatisfied with the number of days it included on the cost report, which does not give rise to appeal rights according to the Medicare Contractor.

Challenges over other issues

The Medicare Contractor challenged jurisdiction over the Labor and Deliver Room Days issue, which the Provider has since withdrawn, therefore the Board will not address the challenge.

The Medicare Contractor has also challenged jurisdiction over the following issues which have been transferred to groups: Medicare Part C Days in the Medicaid fraction; Dual Eligible Days in the Medicaid fraction; and Outlier Payments—Fixed Loss Threshold. Because these issues have been transferred to groups, the Board will not address these jurisdictional challenges.

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.[2] 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.[3] 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.[4]

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,

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[1] The Medicare Contractor identifies the issue as "SSI Realignment."
[2] *See* Provider's September 17, 2014 Jurisdictional Response at 4.
[3] *Id.*
[4] *Id.*

2008 decision. 657 F.3d 1 (D.C. Cir. 2011).[5] The decision here that was abandoned was that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS.[6] Thus, the Provider reasons that the Provider can submit data to prove its SSI percentage was understated.[7] However, the Provider mentions that, to this point, the Provider has been unable to submit such data because CMS has not released the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") data—HHS/HCFA/OIS, 09-07-009, published in the Federal Register on August 18, 2000—in support of the SSI percentage.[8]

The Provider contends that CMS has just now started releasing the MEDPAR data, but the Provider has not yet received its MEDPAR data and has been unable to reconcile its records with that of CMS.[9] The Provider argues that it is unable to specifically identify patients believed to be entitled both to Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal FYE (September 30) when it determined the Provider's SSI percentage.[10] The Provider states that though the Provider may choose to request realignment, this still will not correct these errors of omission and commission that are understating the Provider's SSI percentage.[11] Therefore, the Provider requests that the Board finds that it has jurisdiction over the DSH/SSI "provider specific" and realignment sub-issues.[12]

Issue 2 – Medicaid Eligible Days

The Provider argues that the Board has jurisdiction over the Medicaid eligible days issue because there was an adjustment to its DSH payment on its cost report. Additionally, the Provider argues that the necessary documentation for Medicaid eligible days is not available from the State in time, therefore the days were self-disallowed on its cost report.[13]

Board's Decision

Issue 1 – SSI Provider Specific

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

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that the Provider transferred to case no. 14-1815G and is

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[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id.* (citing 65 Fed. Reg. 50, 548 (2000)).
[9] *Id.*
[10] *Id.* (citing *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008)).
[11] *Id.*
[12] *Id.*
[13] Provider's Jurisdictional Response at 8.

hereby dismissed by the Board.[14] 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."[15] The Provider's legal basis for Issue No. 1 also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] 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."[17]

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

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

The second aspect of Issue No. 1—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[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.

Issue 2 – Medicaid Eligible Days

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

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

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

report under protest.[18]

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

Conclusion

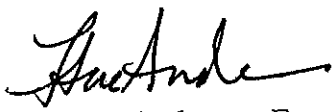
The Board finds that it does not have jurisdiction over the last two issues pending in this appeal: SSI Provider Specific and Medicaid eligible days issues and hereby dismisses these issues from the appeal.

As no issues remain pending in the appeal, PRRB Case No. 14-3848 is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD



L. Sue Andersen, Esq.
Chairperson

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

cc: Wilson Leong, FSS

[18] 42 C.F.R. § 405.1835(a).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAR 2 7 2018

Certified Mail

Michael G. Newell
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RE: Southwest Consulting DSH Part C Days Groups

SWC Baystate Health 2011 DSH SSI Fraction Part C Days CIRP Group, CN 15-1752GC
SWC Baystate Health 2011 DSH Medicaid Fraction Part C Days CIRP Group, CN 15-1753GC
Southwest Consulting Memorial Hermann 2012 DSH SSI Fraction Part C Days CIRP, CN 15-1915GC
Southwest Consulting Memorial Hermann 2012 DSH Medicaid Fraction Part C Days CIRP, CN 15-1917GC
Southwest Consulting Baystate 2012 DSH Medicaid Fraction Part C Days CIRP Group, CN 15-3148GC
Southwest Consulting Baystate 2012 DSH SSI Fraction Part C Days CIRP Group, CN 15-3150GC
Southwest Consulting Memorial Hermann 2013 DSH SSI Fraction Part C Days CIRP Group, CN 16-0042GC
Southwest Consulting Memorial Hermann 2013 DSH Medicaid Fraction Part C Days CIRP Group, CN 16-0043GC
Southwest Consulting Baycare 2013 DSH SSI Fraction Part C Days Group, CN 16-0573GC
Southwest Consulting Baycare 2013 DSH Medicaid Fraction Part C Days Group, CN 16-0574GC
Southwest Consulting Baystate 2013 DSH SSI Fraction Part C Days CIRP Group, CN 16-0999GC
Southwest Consulting Baystate 2013 DSH Medicaid Fraction Part C Days CIRP Group, CN 16-1000GC
Southwest Consulting Covenant Health 2013 DSH SSI Fraction Part C Days CIRP Group, CN 16-1342GC
Southwest Consulting Covenant Health 2013 DSH Medicaid Fraction Part C Days CIRP Group, CN 16-1343GC
Southwest Consulting Orlando Health 2013 DSH SSI Fraction Part C Days CIRP Group, CN 16-1504GC
Southwest Consulting Orlando Health 2013 DSH Medicaid Fraction Part C Days CIRP Group, CN 16-1505GC
Southwest Consulting Conemaugh 2014 DSH SSI Fraction Part C Days CIRP Group, CN 16-2416GC
Southwest Consulting Conemaugh 2014 Pre-10/1/2013 DSH Medicaid Fraction Part C Days CIRP, CN 16-2417GC
Southwest Consulting UPMC 2014 DSH SSI Fraction Part C Days CIRP Group, CN 16-2542GC
Southwest Consulting UPMC 2014 Pre-10/1/2013 DSH Medicaid Fraction Part C Days CIRP, CN 16-2545GC

Dear Mr. Newell:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' March 14, 2018 request for expedited judicial review (EJR) (received March 19, 2018) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these cases is:

> Whether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator [of the disproportionate share hospital (DSH) adjustment] or vice-versa.[1]

[1] Providers' March 14, 2018 EJR Request at 4.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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 CMS, and the Medicare Administrative Contractors (MACs) use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the intermediaries to calculate DSH payments for the FY 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 FFY 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[17] In response to a comment regarding this change, the Secretary explained that:

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

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[13] *Id.*

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

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

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

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

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

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

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

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

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] Providers' EJR request at 1.
[22] 69 Fed. Reg. at 49,099.

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] 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. 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 timely filed appeals involving fiscal years 2011 through 2014.

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost reports for the period where the providers seek payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing cost reports under protest.[24] For appeals of RNPRs issued after August 21, 2008, the Board only has jurisdiction to hear a provider's appeal of matters that the Medicare contractor specifically revised within the RNPR.[25] The Board notes that the revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that each of the participants timely filed an appeal from their respective determination. The Providers involved with the instant EJR request that have appealed from an original NPR have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. The Providers which filed appeals from revised

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[23] *Allina* at 1109.
[24] *See* 42 C.F.R. § 405.1835(a)(1) (2008).
[25] *See* 42 C.F.R. § 405.1889(b)(1) (2008).

NPRs have adjustments to the SSI percentage, as required for jurisdiction. In addition, the participants' documentation shows that the estimated amount in controversy for each group exceeds the $50,000 threshold as required for jurisdiction[26]. 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 are for fiscal years 2011-2014, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time periods at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.[27]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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[26] *See* 42 C.F.R. § 405.1837.

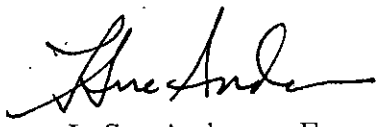
[27] On March 15, 2018, one of Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in PRRB Case Nos. 15-1752GC, 15-1753GC, 15-3148GC, 15-3150GC, 16-0999GC and 16-1000GC. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in Allina. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the providers' requests for EJR for the issue and the subject years. The providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these groups, the Board hereby closes case numbers 15-1752GC, 15-1753GC, 15-1915GC, 15-1917GC, 15-3148GC, 15-3150GC, 16-0042GC, 16-0043GC, 16-0573GC, 16-0574GC, 16-0999GC, 16-1000GC, 16-1342GC, 16-1343GC, 16-1504GC, 16-1505GC, 16-2416GC, 16-2417GC, 16-2542GC and 16-2545GC.

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

FOR THE BOARD:



L. Sue Andersen, Esq.
Chairperson

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

cc: **(Certified Mail w/Schedules of Providers)**
Byron Lamprecht, Wisconsin Physicians Service
Mounir Kamal, Novitas Solutions, Inc.
Geoff Pike, First Coast Service Options
Cecile Huggins, Palmetto GBA
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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MAR 2 7 2018

Certified Mail

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King & Spalding, LLP
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RE: **Expedited Judicial Review Determination**

14-2821GC	Piedmont Healthcare 2011 SSI Percentage Group
16-1466GC	King & Spalding Piedmont Healthcare 2013 DSH Medicaid Fraction Medicare Advantage Days Group
16-1467GC	King & Spalding Piedmont Healthcare 2013 DSH SSI Fraction Medicare Advantage Days Group
17-1453GC	Piedmont Healthcare 2014 DSH Medicare Advantage Days (Pre-10/1/2013) Group

Dear Mr. Hettich:

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

Issue in Dispute

The issue in these appeals is:

> [W]hether CMS unlawfully treats days for which Medicare Part A did not make payment, namely Medicare Advantage days which are paid under Medicare Part C, as days for which patients are entitled to benefits under Medicare Part A for purposes of calculating the Medicare disproportionate share ("DSH") payment.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

[1] March 16, 2018 EJR Request at 1.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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.

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[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[17] 69 Fed. Reg. at 49,099.
[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).

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 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 timely filed appeals involving fiscal years 2011, 2013 and 2014.

For appeals of original NPRs for cost reporting time periods ending on or after December 31, 2008, providers preserve their respective rights to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either including a claim for the specific item on their cost reports for the period

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[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] 69 Fed. Reg. at 49,099.
[22] *Allina* at 1109.

where the providers seek payment they believe to be in accordance with Medicare policy, or self-disallowing the specific item by following the applicable procedures for filing cost reports under protest.[23]

The Board has determined the participants involved with the instant EJR requests have appealed from original NPRs that had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy for each group exceeds the $50,000 threshold as required for jurisdiction[24]. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Requests

The Board finds that:

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

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

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

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

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

[23] *See* 42 C.F.R. § 405.1835(a)(1) (2008).
[24] *See* 42 C.F.R. § 405.1837.

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

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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MAR 2 9 2018

Refer to: 13-2880

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RE:	South Shore Hospital Jurisdictional Challenge
PN:	14-0181
FYE:	12/31/2008
CASE NO.:	13-2880

Dear Ms. Elias and Ms. Hartley,

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

Background:

The Provider submitted a request for hearing on August 14, 2013, based on a Notice of Program Reimbursement ("NPR") dated March 29, 2013. The hearing request only included the Medicare DSH Additional Medicaid Eligible Days issue. The Medicare Contractor submitted a jurisdictional challenge on February 6, 2018 over the Medicare DSH Additional Medicaid Eligible Days. The Provider filed a responsive brief on March 7, 2018.

Medicare Contractor's Position

The Medicare Contractor contends that this issue does not meet the jurisdictional requirements, as an adjustment was not made to the additional Medicaid eligible patient days in question. The Medicare Contractor also asserts that the Provider did not include a protested amount on its as-filed cost report for the additional Medicaid days in accordance with 42 C.F.R. § 405.1835(a)(1)(ii).

The adjustments referenced by the Provider decreased Medicaid paid days by 953 and increased HMO Medicaid days by 176 days (adjustment 7). This adjustment to Medicaid days was to agree

to the Provider's submitted listings.[1] Adjustment 15 was to update the Provider's DSH payment percentage and did not adjust Medicaid days. Therefore, the Provider cannot show dissatisfaction.[2]

The Medicare Contractor explains that effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate PRM 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." The Medicare Contractor contends that the Provider has failed to preserve its right to claim dissatisfaction by properly filing the reimbursement impact of the additional Medicaid eligible days in question as a Protested Amount.[3]

Provider's Position

The Provider argues that the Board has already ruled that it has jurisdiction over this Provider's appeal of Medicaid eligible days for a different cost reporting period. The Provider contends that it was legally prevented from including the Medicaid eligible days at issue on its FY 2008 cost report under 42 CFR 412.106(b)(4)(iii). Therefore, the Medicare Contractor's jurisdictional challenge must be rejected under the holding in *Bethesda Hospital Association V. Bowen*, 485 U.S. 399, 401-406 (1988) ("*Bethesda*") and the reasoning of *Banner Heart Hospital, et al. v. Burwell*, No. 14-cv-01195 (APM) (D.D.C. Aug. 19, 2016) ("*Banner*"), which has been recently upheld by *Bayshore Community Hospital, et al. v. Hargan*, No. 16-cv-2353 (D.D.C.2017).[4]

The Provider asserts that it has additional Medicaid eligible days that should be included in its Medicaid fraction of the DSH percentage. The Provider contends that it had a "practical impediment" to report all Medicaid eligible days on its Medicare as-filed cost report because Illinois Medicaid eligibility records were not available.

The Provider argues that it has met the jurisdictional requirements for Board hearing pursuant to 42 U.S.C. § 1395oo(a). The Provider states that it "is dissatisfied with a specific cost, and it claimed that category of costs on its as-filed FY 2008 Cost Report as completely as it could in accordance with the regulations." The Provider claimed only Medicaid eligible days that it could verify through the state.

The Provider refers to a previous Board jurisdictional decision, PRRB Case No. 13-2885, over this Provider where the Board determined that it had jurisdiction over the additional Medicaid eligible days issue.

Board Decision:

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

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction.....by.....[i]ncluding a claim for specific item(s) on its cost report...or...self-disallowing the specific item(s) by.....filing a cost report under protest.....[5]

The Provider is appealing from a 12/31/2008 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

The Provider did not protest the Medicaid eligible days currently under appeal, on its cost report notwithstanding the fact that it knew Illinois would have additional days at a later point in time. Therefore, the Board could only have jurisdiction over those days if the Provider included a claim for the specific items on its cost report, as required by 42 C.F.R. § 405.1835(a).

The Board finds that the Provider did not include a claim for the specific days at issue in this appeal on its cost report. Therefore, the Board finds that South Shore Hospital has not met the dissatisfaction requirement of including a specific claim on the cost report, or protesting the specific Medicaid eligible days at issue, conclude that it does not have jurisdiction over the issue, and dismisses the issue from the appeal.

While the Provider argues that *Bethesda, Banner* and *Bayshore* apply to the subject appeal, the Board concludes that the Provider was not precluded from claiming additional Medicaid eligible days on its cost report as a protested item. Therefore, the cited court cases do not pertain to the issue in the subject appeal. The District Court in *Banner* concluded that the Board "violates the administrative appeal provision of the Medicare statute and the key Supreme Court precedent interpreting it, *Bethesda*". *Bethesda* emphasizes the futility of presenting a legal challenge to an intermediary when the intermediary has no authority to entertain or decide such challenges. Again, the Board finds that it was not futile for the Provider to claim the Medicaid eligible days as a protested item as required under 42 C.F.R. § 405.1835(a)(1)(ii) (2008). The Board is bound by the regulation and concludes that it does not have jurisdiction over the Medicaid eligible days issue because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i) (2008) or 42 C.F.R. § 405.1835(a)(1)(ii) (2008). Were it not for 42 C.F.R. § 405.1835(a)(1)(ii) (2008), the issue would fall under the threshold criteria set forth in *Bethesda*, and the Board would find jurisdiction.

The Provider also refers to a previous Board decision, PRRB Case No. 13-2885. However, that case was for fiscal year end 12/31/2007 which was before the requirement to file a cost report claim under 42 C.F.R. § 405.1835(a)(1)(ii) (2008).

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[5] 42 C.F.R. § 405.1835(a).

The Board dismisses the Medicaid eligible days for the subject appeal and hereby, closes Case No. 13-2880. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

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DEPARTMENT OF HEALTH & HUMAN SERVICES

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MAR 29 2018

Refer to: 14-4187

CERTIFIED MAIL

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National Government Services
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RE:	South Shore Hospital Jurisdictional Challenge
PN:	14-0181
FYE:	12/31/2011
CASE NO.:	14-4187

Dear Ms. Elias and Ms. Hartley,

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

Background:

The Provider submitted a request for hearing on September 8, 2014, based on a Notice of Program Reimbursement ("NPR") dated March 17, 2014. The hearing request included only the Medicare DSH Additional Medicaid Eligible Days issue. The Medicare Contractor submitted a jurisdictional challenge on August 25, 2015. The Provider filed a responsive brief on January 2, 2018.

Medicare Contractor's Position

The Medicare Contractor contends that this issue does not meet the jurisdictional requirements, as an adjustment was not made to the additional Medicaid eligible patient days in question. The Medicare Contractor requested additional documentation to consider the additional Medicaid eligible days. However, the Provider was late submitting the documentation. Therefore, the Medicare Contractor did not review or include the additional days.

The only adjustments made by the Medicare Contractor to the Provider's DSH reimbursement were to correct the SSI percentage (adjustment 9) and update to a more current PS&R report

(adjustment 10). The effect of these adjustments increased the Provider's DSH reimbursement by $34,287.[1]

The Provider submitted a response to Alert 10[2], stating "it did not have a process in place to identify Medicaid eligible unpaid days." Medicare Contractor argues that the Provider has had ample time to develop a process to accumulate Medicaid eligible unpaid days since HCFA Ruling 97-2 was issued many years before the fiscal year in this appeal. Therefore, the Provider's argument that it does not have a process in place is not an adequate reason for not maintaining auditable documentation in accordance with 42 CFR 413.20 and 413.24.[3]

The Medicare Contractor argues that in the case at issue it did not make an adjustment for the additional Medicaid eligible days in question. Therefore, it is clear that the requisite "determination of the Secretary" under 1878(a)(1)(A)(ii) of the Social Security Act does not exist in this case.[4]

The Medicare Contractor explains that effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate PRM 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." The Medicare Contractor contends that the Provider has failed to preserve its right to claim dissatisfaction by properly filing the reimbursement impact of the additional Medicaid eligible days in question as a Protested Amount.[5]

Provider's Position

The Provider contends that it was legally prevented from including the Medicaid eligible days at issue on its FY 2011 cost report under 42 CFR 412.106(b)(4)(iii). Therefore, the Medicare Contractor's jurisdictional challenge must be rejected under the holding in *Bethesda Hospital Association V. Bowen*, 485 U.S. 399, 401-406 (1988) ("*Bethesda*") and the reasoning of *Banner Heart Hospital, et al. v. Burwell*, No. 14-cv-01195 (APM) (D.D.C. Aug. 19, 2016) ("*Banner*"), which has been recently upheld by *Bayshore Community Hospital, et al. v. Hargan*, No. 16-cv-2353 (D.D.C.2017).[6]

The Provider asserts that it has additional Medicaid eligible days that should be included in its Medicaid fraction of the DSH percentage. The Provider contends that it had a "practical impediment" to report all Medicaid eligible days on its Medicare as-filed cost report because Illinois Medicaid eligibility records were not available.

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[1] Medicare Contractor's jurisdictional challenge at 2.
[2] **Note**: Alert 10 response for Case No. 14-4187 was submitted to the Medicare Contractor as part of the Provider's Preliminary Position Paper but not to the Board. *See* Medicare Contractor's jurisdictional challenge at Exhibit I-6; Medicare Contractor's Final Position Paper at Exhibit I-8.
[3] Medicare Contractor's jurisdictional challenge at 3.
[4] Medicare Contractor's jurisdictional challenge at 3.
[5] Medicare Contractor's jurisdictional challenge at 4.
[6] Provider's jurisdictional response at 2.

The Provider argues that it has met the jurisdictional requirements for Board hearing pursuant to 42 U.S.C. § 1395oo(a). The Provider states that it "is dissatisfied with a specific cost, and it claimed that category of costs on its as-filed FY 2011 Cost Report as completely as it could in accordance with the regulations." The Provider claimed only Medicaid eligible days that it could verify through the state.

The Provider refers to a previous Board jurisdictional decision, PRRB Case No. 13-2885, over this Provider where the Board determined that it had jurisdiction over the additional Medicaid eligible days issue.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction.....by.....[i]ncluding a claim for specific item(s) on its cost report...or...self-disallowing the specific item(s) by.....filing a cost report under protest.....[7]

The Provider is appealing from a 12/31/2011 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

The Provider did not protest the Medicaid eligible days, currently under appeal, on its cost report notwithstanding the fact that it knew Illinois would have additional days at a later point in time. Therefore, the Board could only have jurisdiction over those days if the Provider included a claim for the specific items on its cost report, as required by 42 C.F.R. § 405.1835(a).
The Board finds that the Provider did not include a claim for the specific days at issue in this appeal on its cost report. Therefore, the Board finds that South Shore Hospital has not met the dissatisfaction requirement of including a specific claim on the cost report, or protesting the specific Medicaid eligible days at issue, concludes that it does not have jurisdiction over the issue, and dismisses the issue from the appeal.

While the Provider argues that *Bethesda, Banner* and *Bayshore* apply to the subject appeal, the Board concludes that the Provider was not precluded from claiming additional Medicaid eligible days on its cost report as a protested item. Therefore, the cited court cases do not pertain to the issue in the subject appeal. The District Court in *Banner* concluded that the Board "violates the administrative appeal provision of the Medicare statute and the key Supreme Court precedent interpreting it, *Bethesda*". *Bethesda* emphasizes the futility of presenting a legal challenge to an intermediary when the intermediary has no authority to entertain or decide such challenges.

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[7] 42 C.F.R. § 405.1835(a).

Again, the Board finds that it was not futile for the Provider to claim the Medicaid eligible days as a protested item as required under 42 C.F.R. § 405.1835(a)(1)(ii) (2009). The Board is bound by the regulation and concludes that it does not have jurisdiction over the Medicaid eligible days issue because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i) (2009) or 42 C.F.R. § 405.1835(a)(1)(ii) (2009). Were it not for 42 C.F.R. § 405.1835(a)(1)(ii) (2009), the issue would fall under the threshold criteria set forth in *Bethesda*, and the Board would find jurisdiction.

The Provider also refers to a previous Board decision, PRRB Case No. 13-2885. However, that case was for fiscal year end 12/31/2007 which was before the requirement to file a cost report claim under 42 C.F.R. § 405.1835(a)(1)(ii) (2009).

The Board dismisses the Medicaid eligible days for the subject appeal and hereby, closes Case No. 14-4187.

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
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Charlotte F. Benson, CPA
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FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

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

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RE: Jurisdictional Decision
Provider: Houston Methodist Sam Jacinto Hospital
Case Number: 15-2261
FYE: 12/31/2012

Dear Ms. Chi and Mr. Kamal:

Background

Houston Methodist San Jacinto Hospital, or the Provider, is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. The Provider filed the request for appeal on April 16, 2015 regarding a Notice of Program Reimbursement dated October 24, 2014. There were seven issues stated in the Model Form A – Individual Appeal Request:

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

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

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

4) Disproportionate Share Hospital Payment – Medicaid Eligible Days,

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

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

7) Whether Capital IME and DSH were calculated correctly.

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

1) Issue No. 3 to Case No. 16-0439GC,

2) Issue No. 5 (bifurcated) to Case No. 16-0440GC and 16-0448GC, and

3) Issue Nos. 6 (bifurcated) to Case No. 16-0449GC and 16-0447GC,

Issue Nos. 1, 2, 4 and 7 remain in the appeal. The Medicare Contractor has filed a Jurisdictional Challenge (Jan. 31, 2018) regarding Issue Nos. 1, 2 and 4.

Medicare Contractor's Position

The Medicare Contractor's position is that the Provider makes the same argument in Issue No. 1 (DSH SSI Percentage Realignment), Issue no. 2 (DSH SSI Percentage Provider Specific), and Issue No. 3 (DSH SSI Percentage Systemic Errors), as the Provider claims in all three issues that the SSI percentage applied to its cost report is incorrect. The Medicare Contractor points out that the Provider has transferred Issue No. 3 (DSH SSI Percentage Systemic Errors) to Case No. 16-0439GC, and under the Board Rules the Provider cannot have a duplicative SSI percentage issues in different appeals. Therefore, the Medicare Contractor asks the Board to dismiss Issue Nos. 1 and 2.

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

The Provider's Position

The Provider filed a Jurisdictional Response (Feb. 20, 2018). The Provider claims Issue Nos. 1 (DSH SSI Percentage Realignment) and 2 (DSH SSI Percentage Provider Specific) are different than Issue No. 3 (DSH SSI Percentage Systemic Errors) because they address errors that do not fit into the systemic error category. The Provider contends the DSH SSI Provider Specific issue seeks to correct the SSI percentage as it is understated due to patients identified which are entitled to both Medicare Part A and SSI. The Provider states it is entitled to appeal this issue because the Medicare Contractor adjusted the DSH SSI percentage and it has met the dissatisfaction requirement.

With regards to Issue No. 4 (DSH Medicaid Eligible Days), the Provider claims the issuance of a Notice of Program Reimbursement and a timely appeal "trigger" the Board's jurisdiction over the Provider. Additionally, the Provider states adjustment nos. 4 and 27 adjusted both DSH and Medicaid Eligible Days, and these adjustments warrant Board jurisdiction over the appeal. However, the Provider also claims that adjustments are not required for Board jurisdiction as the DSH payment is not an item that has to be claimed or adjusted on the cost report. The Provider argues that the documentation was not available from the State in time to include all DSH Medicaid Eligible days on the cost report, and therefore the Provider self- disallowed the cost in accordance with Board Rule 7.2(B). Lastly, the Provider asserts the requirement to either claim or protest a specific cost is an invalid requirement, which even if valid does not apply to this situation pursuant to *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988).

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction . . . by . . . [i]ncluding a claim for specific item(s) on its cost report . . . or . . . self-disallowing the specific item(s) by . . . filing a cost report under protest.[1]

[1] 42 C.F.R. § 405.1835(a) (emphasis added).

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

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

Issue No. 1 contends that the "SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation."[2] The Provider also states it "is seeking SSI data from CMS in order to reconcile its records with CMS data…" and that the Provider "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[3] The Provider cites to Adjustment Nos. 4, 13, 26 and 27 regarding this issue, and states an estimated amount in controversy of $52,087.

Identically, Issue No. 2 contends that the "SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation."[4] The Provider claims it "is seeking SSI data from CMS in order to reconcile its records with CMS data…"[5] The Provider cites to Adjustment Nos. 4, 13, 26 and 27, and states an estimated amount in controversy of $52,087.

The Provider describes Issue No. 3, which has been transferred to Case No. 16-0439GC, as "the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the [Medicare Contractor] to settle their Cost Report was incorrectly computed" for the following reasons:

1) Availability of data from MedPAR[6] and SSA[7] Records,

2) Paid Days versus Eligible Days,

3) Not in Agreement with Provider's Records,

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[2] Provider's Model Form A – Individual Appeal Request (Apr. 15, 2015), Tab 3 at 1.
[3] *Id.*
[4] Provider's Model Form A – Individual Appeal Request (Apr. 15, 2015), Tab 3 at 2.
[5] *Id.*
[6] Medicare Provider Analysis and Review Files
[7] Social Security Administration

4) Fundamental Problems in the SSI Percentage Calculation,

5) Covered Days versus Total Days,

6) Non-Covered Days,

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

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

The Board finds it has jurisdiction over the portion of Issue No. 1 (DSH SSI Percentage Realignment) and Issue No. 2 (DSH SSI Percentage Provider Specific) challenging the data used to calculate the SSI percentage as there was an adjustment to the DSH SSI percentage (Adj. 27), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that the inaccurate data portion of both Issue Nos. 1 and 2 is duplicative of Issue No. 3, the DSH SSI Percentage Accurate Data issue, which was transferred to Case No. 16-0439GC. The basis of all three Issues is that the SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. Issue Nos. 1 and 2 are hereby dismissed from the appeal because they are duplicative of Issue No. 3 (which is prohibited) and now reside in Case No. 16-0439GC.

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

DSH Medicaid Eligible Days Issue (No. 4)

The Provider is appealing from a 12/31/2012 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

As stated above, pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not this

hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction . . . by . . . [i]ncluding a claim for specific item(s) on its cost report...or...self-disallowing the specific item(s) by . . . filing a cost report under protest.

The Provider cited to several adjustments, and also indicated that the issue was self-disallowed in its jurisdictional response. While Adjustment No. 4 did add 120 DSH Medicaid Eligible Days, there is nothing in the record to indicate that the Provider claimed the 29 additional Medicaid Eligible Days it now seeks on its cost report or that it included these 29 days as a protested amount.[8] Therefore, the Board finds that it does not have jurisdiction over Issue No. 4 regarding DSH Medicaid Eligible Days and this issue is dismissed from the appeal.

Issue Nos. 1, 2 and 4 are dismissed from the appeal for the reasons stated above. The appeal will remain open for resolution of Issue No. 7. Review of this decision may be available under 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members

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Gregory H. Ziegler, CPA, CPC-A

FOR THE BOARD

L. Sue Andersen, Esq.
Chairperson

cc: Wilson Leong, Esq., FSS

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