DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

MAY 01 2018

H. Anne Browne
Sr. Appeals Analyst Reimbursement Dept.
HCA, Inc.
One Park Plaza, Building FP-4
Nashville, TN 37203

RE: North Austin Medical Center, Provider No. 45-0809, FYE 06/30/2013, Case No. 18-0489

Dear Ms. Browne:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned individual appeal and finds that it does not have jurisdiction over the matter. The specific facts with regard to the case and the Board's determination are set forth below.

Pertinent Facts:

The Notice of Program Reimbursement (NPR) for North Austin Medical Center's 2013 cost reporting period was issued on July 28, 2017 and 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).

On October 25, 2017, the Provider submitted a Request to Recalculate SSI based on Hospital's Fiscal Year to the Medicare Contractor.

HCA filed an appeal on behalf of the Provider on January 12, 2018 based on the July 28, 2017 NPR. The sole issue in the individual appeal is characterized as "[w]hether the SSI% used in the disproportionate share percentage ["DSH"] on the Notice of Program Reimbursement ["NPR"] correctly reflected the "routine use data" for the provider's cost report year."

Board Determination:

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

Although the Medicare Contractor did not challenge jurisdiction over the issue in this case, the Board finds that it does not have jurisdiction. The issue under appeal deals with the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. 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 . . . ."

In the Provider's issue statement, it indicates "[t]he Provider would qualify for an additional DSH payment . . . if the SSI % used on the NPR in the DSH percentage were changed to incorporate the routine use data for the Provider's cost reporting year from July 1, 2012 through June 30, 2013."[1] As noted above, although the Provider filed a Request to Recalculate SSI based on the Hospital's Fiscal Year with the Medicare Contractor on October 25, 2017, the Medicare Contractor has not issued 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 issue and dismisses it from the appeal. Since there are no other issues pending in the appeal, the Board hereby closes case number 18-0489 and removes it from the docket.

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

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

FOR THE BOARD

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

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

[1] Provider Appeal at Tab 3.

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410-786-2671

CERTIFIED MAIL

MAY 01 2018

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

RE: St. Mary's Medical Center, Provider No. 05-0300, FYE 06/30/2012, Case No. 15-2342

Dear Ms. Giberti:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned individual appeal. We note that the Provider appealed from a Notice of Program Reimbursement (NPR) for a 2012 cost reporting period. The NPR, which was issued on October 29, 2014, 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). The specific facts with regard to the case and the Board's determination are set forth below:

Pertinent Facts:

The Provider filed an appeal on April 21, 2015 from the NPR issued on October 29, 2014.

There are two remaining issues in the individual appeal:
1. Additional Medicaid Eligible Days and
2. the SSI Ratio Alignment to Provider's Cost Reporting Year.[1]

The SSI Realignment issue under appeal deals with the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

Board Determination:

Although the Medicare Contractor did not challenge jurisdiction over the SSI Realignment issue, the Board finds it does not have jurisdiction over this issue. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." In the Provider's issue statement, it indicates "[t]he Provider will consider requesting CMS realign the Provider's SSI Percentage to the provider's cost reporting year."[2] Therefore, a request to CMS has not yet been made. Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied for appeal purposes.

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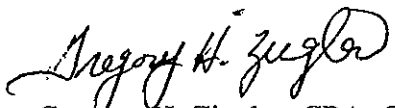
[1] All other issues have been transferred to group appeals.
[2] Provider Appeal at Tab 3, Issue 7.

Therefore, the Board finds it lacks jurisdiction over the SSI Realignment issue and dismisses it from the appeal. The Medicaid Eligible Days issue remains pending and will be scheduled for hearing under separate cover.

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

MAY 01 2018

James F. Flynn, Esq.
Bricker & Eckler LLP
100 South Third Street
Columbus, OH 43215 4291

RE: Grady Memorial Hospital, Provider No. 36-0210, FYE 06/30/2010, Case No. 14-2413

Dear Mr. Flynn:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned individual appeal and finds that it does not have jurisdiction over the matter. The specific facts with regard to the case and the Board's determination are set forth below.

Pertinent Facts:

The Notice of Program Reimbursement (NPR) for Grady Memorial Hospital's 2010 cost reporting period was issued on August 21, 2013 and 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).

On February 14, 2014, Bricker & Eckler filed an appeal on the Provider's behalf based on the August 21, 2013 NPR. The sole issue in the individual appeal was characterized as the "[S]hift to provider's cost report year for calculation of the [disproportionate share percentage] DSH percentage."[1,2]

Board Determination:

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

Although the Medicare Contractor did not challenge jurisdiction over the issue in this case, the Board finds that it does not have jurisdiction. The issue under appeal deals with the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. 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 . . . ."

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[1] Provider Appeal at Tab 3

[2] The Provider added the Dual Eligible Days issue to the case on April 18, 2014, but the issue was simultaneously transferred to a common issue related party (CIRP) group, Case No 14-3067GC.

In the Provider's issue statement, it indicates that it has already requested data from CMS to make a determination regarding whether the calculation should be based on the provider's cost report year instead of the FYE. Further, the Provider explains that, **once the information is received from CMS, it will evaluate the data and then make the appropriate request** to perform the "shift." (emphasis added)

As the Provider acknowledges, it has not yet received the information from CMS. Consequently, a request for recalculation has not yet have been filed. Since the Medicare Contractor has not issued a final determination from which the Provider can be dissatisfied for appeal purposes, the Board finds that it does not have jurisdiction over the realignment issue and dismisses it from the appeal. Since there are no other issues pending in the appeal, case number 14-2413 is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD,

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

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

cc: Judith Cummings, CGS Administrators (J-15)
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

MAY 01 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**

17-0043G Southwest Consulting 2014 (pre 10/31/2013) DSH Medicaid Fraction Group

Dear Mr. Newell:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' April 19, 2018 request for expedited judicial review (EJR) (received April 23, 2018)[1] for the above-referenced appeal. 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.[2]

Statutory and Regulatory Background: Medicare DSH Payment

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

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] These cases involves the hospital-specific DSH adjustment, which requires the

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[1] The EJR request listed two additional cases, 17-1333G and 17-1334G. The Board will issue an EJR determination under separate cover in those cases.
[2] Providers' EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).

Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients. [6]

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

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

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

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

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

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

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

The 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.[11]

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[19] (emphasis added)

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

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

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

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] 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

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

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 year 2014, prior to October 31, 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.[24] 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 determinations. 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. In addition, the participants' documentation shows that the estimated amount in controversy for the 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 year 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

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

31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these groups, 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: Bruce Snyder, Novitas Solutions (Certified Mail w/Schedules of Providers)
Wilson Leong, FSS (Certified Mail w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 01 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**

14-3713GC	Baptist Health 2009 DSH SSI Fraction Medicare Advantage Days CIRP Group
14-3714GC	Baptist Health 2009 DSH Medicaid Fraction Medicare Advantage Days CIRP Group
15-0557GC	Baptist Health 2010 DSH SSI Fraction Medicare Advantage Days CIRP Group
15-0558GC	Baptist Health 2010 DSH Medicaid Fraction Medicare Advantage Days CIRP Group
15-2132GC	Baptist Health 2012 DSH Medicare/Medicaid Medicare Advantage Days CIRP
16-1207GC	Baptist Health 2013 DSH SSI Fraction Medicare Advantage Days CIRP Group
16-1208GC	Baptist Health 2013 DSH Medicaid Fraction Medicare Advantage Days CIRP Group
14-1161GC	Baptist Health 2013 DSH Medicaid Fraction Medicare Advantage Days CIRP Group

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' April 13, 2018 requests for expedited judicial review (EJR) (received April 16, and 17, 2018) for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> [W]hether CMS unlawfully treats days for which Medicare Part A did not make payment, namely Medicare Advantage days which are paid under Medicare Part C, as days for which patients are entitled to benefits under Medicare Part A for purposes of calculating the Medicare disproportionate share ("DSH") payment.[1]

[1] Providers' EJR Request at 1.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.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 filed appeals involving fiscal years 2009, 2010, 2012, and 2013.

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

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in

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[21] 69 Fed. Reg. at 49,099.
[22] *Allina* at 1109.
[23] *See* 42 C.F.R. § 405.1835 (2008).

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 2009, 2010, 2012, and 2013, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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

[24] *See* 42 C.F.R. § 405.1837.

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

Board Members Participating:

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 01 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**

Indiana University Health 2009 DSH Medicare/Medicaid Part C Days CIRP Group
Case No. 13-3093GC

Community Healthcare System 2009 Medicare/Medicaid Medicare Advantage Days CIRP Group, Case No. 13-3406GC

ProMedica Health System 2009 DSH Medicare/Medicaid Part C Days CIRP Group
Case No. 14-1519GC

Beacon Health System 2009 DSH Medicare/Medicaid Part C Days CIRP Group
Case No. 14-0458GC

Good Shepherd Health System 2009 DSH Medicare/Medicaid Part C Days CIRP Group
Case No. 14-1681GC

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' April 18, 2018 request for expedited judicial review (EJR) (received April 19, 2018). The Board's determination is set forth below.

Issue

The issue for which EJR has been requested is:

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

[1] EJR Request at 2.

Statutory and Regulatory Background: Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[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"[9] fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

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

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

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

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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] "SSI" stands for "Supplemental Security Income."
[10] 42 C.F.R. § 412.106(b)(2)-(3).

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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[14] *Id.*

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

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

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

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

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

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

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

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

Providers' Request for EJR

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

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

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

The Providers argue that any Medicare Advantage days that are also dual eligible days cannot be counted in the Medicare ratio for the same reasons as set forth above. Primarily, they believe, the regulation requiring inclusion of dual eligible days in the Medicare ratio is invalid and the days must be counted in numerator of the Medicaid fraction. This allegedly improper treatment resulted in the under payment to Providers as DSH eligible providers of services to indigent patients, and includes any other related adverse impact to DSH payments, such as capital DSH payments.[25]
With respect to EJR, the Providers believe that the Board has jurisdiction over the matter at issue and lacks the legal authority to decide the legal question presented. The Providers posit that the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the APA and the statute and is bound by Secretary's actions. The Providers do not believe that the Board has the authority to implement the effect of *Allina I* and *Allina II* decisions until the Secretary instructs it to do so.[26]

Decision of the Board

Board's Authority

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

Jurisdictional Requirements

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

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

In the groups included in this EJR request, the Providers filed appeals of their original notices of program reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2009.

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

Jurisdiction

The Board finds that the Providers involved with the instant EJR request have had Part C days excluded from the Medicaid fraction and have had a specific adjustment to the SSI fraction such that the Board has jurisdiction to hear their respective appeals.[28] In addition, the Providers' documentation shows that the estimated amount in controversy for the group appeals exceed $50,000 and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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

The Providers within this EJR request filed appeals covering calendar year 2009, thus the cost reporting period falls squarely within the time frame that covers the Secretary's final rule being challenged.[29] In addition, the Board recognizes that the D.C. Circuit vacated the regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). In addition, within its July 25, 2017 decision in *Allina Health Services v. Price*, the D.C. Circuit Court agreed with the Board's determination to grant EJR for the identical issue involved in the instant EJR request.[30]

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[28] On April 19, 2018, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed objections to the EJR requests for PRRB Case Nos. 13-3093GC, 13-3406GC and 14-0458GC. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since the Board is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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 in each group appeal, the Board hereby closes the cases.

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

FOR THE BOARD:

L. Sue Andersen, Esq.
Chairperson

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

Certified w/ Schedules of Providers
cc: Elizabeth Elias, Hall Render
Mounir Kamal, Novitas Solutions, Inc.
Judith E. Cummings, CGS Administrators
Byron Lamprecht, Wisconsin Physicians Service
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

MAY 02 2018

CERTIFIED MAIL

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

RE: HRS PrimeHealthcare 2012 SSI Percentage Group, CN 15-0476GC
Specifically the following Providers with pending individual appeals:
Paradise Valley Hospital, 05-0024, 12/31/2012, CN 15-0482
Encino Hospital Medical Center, 05-0158, 12/31/2012, CN 15-0872
Garden Grove Hospital & Medical Center, 05-0230, 12/31/2012, CN 15-0653
West Anaheim Regional Medical Center, 05-0426, 12/31/2012, CN 15-0873
Huntington Beach Hospital, 05-0526, 12/31/2012, CN 15-0851
LaPalma Intercommunity Hospital, 05-0580, 12/31/2012, CN 15-0652
Chino Valley Medical Center, 05-0586, 12/31/2012, CN 15-0870
San Dimas Community Hospital, 05-0588, 12/31/2012, CN 15-0487
Desert Valley Hospital, 05-0709, 12/31/2012, CN 15-0488
Centinela Hosptial Medical Center, 05-0739, 12/31/2012, CN 15-0853
Sherman Oaks Hospital, 05-0755, 12/31/2012, CN 15-0480
Alvarado Hospital Medical Center, 05-0757, 12/31/2012, CN 15-0649
Montclair Hospital Medical Center, 05-0758, 12/31/2012, CN 16-1590
Shasta Regional Medical Center, 05-0764, 12/31/2012, CN 15-0486
St. Mary's Regional Medical Center, 29-0009, FYE 12/31/2012, CN 15-3401
St. Mary Passaic, 31-0006, FYE 12/31/2012, CN 16-1627
Lower Bucks Hospital, 39-0070, 12/31/2012, CN 16-1600
Lower Bucks Hospital, 39-0070, 06/30/2012, CN 15-2209
Roxborough Memorial Hospital, 39-0304, 12/31/2012, CN 15-2735
Knapp Medical Center, 45-0128, 06/30/2012, CN 15-0474
Dallas Medical Center, 45-0379, 12/31/2012, CN 15-2706

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned group and the related individual appeals. We note that each of the Providers listed above appealed from a Notice of Program Reimbursement (NPR) for a 2012 cost reporting period. The NPRs, which were issued after May 2014, were issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching).[1] A number of the Providers are also appealing common issues in their individual appeals that meet the requirements for common issue related party (CIRP) groups. The specific facts with regard to each common issue and the Board's determinations are set forth below:

[1] A number of participants filed from the Medicare Contractor's failure to issue a timely final determination to which NPR based appeals were subsequently added, except Centinela Hospital Medical Center which did not incorporate an appeal of its NPR.

I. SSI Provider Specific Only

The sole issue remaining in case numbers **15-0474, 15-0482, 15-0486, 15-0649, 15-0652, 15-0653, 15-0853, 15-0872, 15-0873, 15-2209, 15-3401, 16-1590, 16-1600 and 16-1627** is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. Each of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue directly into the CIRP group, case number 15-0476GC.[2]

The Providers are appealing two components of the SSI Percentage: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

With regard to the first aspect of the issue—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—the Board finds it is duplicative of the Systemic Errors issue that was directly added to 15-0476GC and this aspect is hereby dismissed by the Board.[3]

With regard to the second aspect of the SSI Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—the Board finds it lacks jurisdiction and dismisses this aspect of the issue. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." The regulation permits one such request per year and the resulting percentage becomes the hospital's official Medicare/SSI percentage. In this case, the Providers have not made this request. Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can appeal. As a result the Board finds that the appeal of this issue is premature.[4]

Since there are no other issues in these cases, the Board hereby closes case numbers **15-0474, 15-0482, 15-0486, 15-0649, 15-0652, 15-0653, 15-0853, 15-0872, 15-0873, 15-2209, 15-3401, 16-1590, 16-1600 and 16-1627** and removes them from the Board's docket.

II. SSI Provider Specific and Rural Floor Budget Neutrality Adjustment (RFBNA)

The Providers in case numbers **15-0480, 15-0487, 15-0870, 15-2706 and 15-2735** also appealed directly into the CIRP 15-0476GC and have the SSI Provider Specific issue pending in their individual appeals. These Providers have also appealed the RFBNA issue. Because the Providers are commonly owned by Prime Healthcare and are appealing a common issue (RFBNA) that meets the $50,000 threshold, a new group appeal has been established for the RFBNA issue, to which the Board has assigned case number 18-1184GC.

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[2] A number of Providers also transferred the SSI Percentage issue to the CIRP from their pending individual appeals as well.
[3] Providers' Individual Appeal Requests at Tab 3, Issue 1 and Appeal Request in 15-0476GC.
[4] This determination is not dependent upon the issuance of an NPR and is not a component of the Medicare Contractor's failure to issue a final determination.

In addition, as indicated above, the Providers' challenges to the DSH SSI regulation and statute are already properly pending in a CIRP Group and the potential requests for realignment are premature. Therefore, the Board finds that it does not have jurisdiction over either portion of the issue and hereby dismisses it from the above-referenced appeals. Further, after transferring the RFBNA issue to the newly formed group, there are no issues remaining in these cases. Therefore, case numbers **15-0480, 15-0487, 15-0870, 15-2706 and 15-2735** are also closed and removed from the Board's docket.

III. SSI Provider Specific, RFBNA and Eligible Days

The Provider in case number **15-0851** has a similar fact pattern to the Providers detailed above in section II, but in addition to the Provider Specific SSI and the RFBNA issues, this Provider also appealed the Medicaid Eligible Days issue. This case, however, requires further explanation.

HRS filed the initial appeal request for Huntington Beach Hospital based on the Medicare Contractor's failure to timely issue a final determination. The issues in the appeal included the SSI Provider Specific issue and Medicaid Eligible Days, among others which were subsequently transferred to various CIRP groups. When HRS filed the preliminary position paper, on August 14, 2015, the only issue briefed was the SSI Provider Specific issue as the Medicaid Eligible Days issue was being withdrawn.

Subsequently, HRS filed an appeal on behalf of the Provider on September 23, 2015 which was based on the issuance of an NPR. The NPR based appeal included only two issues: the Medicaid Eligible Days issue and SSI Provider Specific issues. On September 29, 2015, the Board incorporated this appeal into case number 15-0851 and advised that a supplemental preliminary position paper covering the NPR based issues was due from the Representative within 120 days of the date of the email. The Board has no record of a supplemental preliminary position paper being filed from the Representative. Therefore, the Medicaid Eligible Days issue filed from the NPR based appeal was never briefed and is considered to have been abandoned.

With regard to the SSI Provider Specific and RFBNA issues, as in the individual appeals in Sections I and II above, the Provider's challenge to the DSH SSI regulation and statute are already properly pending in a CIRP Group (15-0476GC) and the potential request for realignment is premature. Therefore, the Board finds that it does not have jurisdiction over either portion of the issue in this case and hereby dismisses the SSI Provider Specific issue from the appeal. Further, after transferring the RFBNA issue to case number 18-1184GC, there are no remaining issues in case number 15-0851. Therefore, it is being closed and removed from the Board's docket.

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

IV. SSI Provider Specific and Low Income Health

The Provider in case number **15-0488** has the SSI Provider Specific issue pending in its individual appeal and transferred it (as well as filing a request that the issue be directly added) into the CIRP group (15-0476GC). In addition the Provider also appealed the Low Income Health Issue in its individual case. HRS briefed the SSI Provider Specific issue in its initial preliminary position paper

individual case. HRS briefed the SSI Provider Specific issue in its initial preliminary position paper and briefed the Low Income Health issue in a supplemental preliminary position paper filed on September 21, 2016. All other issues in this case were either transferred to CIRP groups or withdrawn. The Board denies jurisdiction over the SSI Provider Specific issue as being duplicative/premature for this Provider.

With regard to the Low Income Health issue, the Board has not found it pending in any of the related individual appeals for FYE 2012. Therefore, the Low Income Health issue remains the sole issue in the individual appeal, case number 15-0488 which will remain open. The Parties will receive a Notice of Hearing scheduling the case for a hearing date under separate cover.

RFBNA Group Status

Finally, as the NPRs for the 2012 FYE for these commonly owned Providers were issued between 2014 and 2015, please advise the Board whether the newly formed CIRP group, case number 18-1184GC, is fully formed. Your written response is due to the Board within 60 days of the date of this letter. If the group is not fully formed, within the same time frame, identify the Providers for which you are awaiting the issuance of an NPR that will be added to the CIRP group. Failure to submit a timely response to this request will result in dismissal of case number 18-1184GC.

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

FOR THE BOARD

L. Sue Andersen, Esq.
Board Member

Enclosures: Group Acknowledgement Letter for Case No. 18-1184GC
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: *With Enclosures*
Lorraine Frewert, Noridian Healthcare Solutions (J-E)
Byron Lamprecht, Wisconsin Physicians Service (J-8)
Bruce Snyder, Novitas Solutions, Inc. (J-L)
Mounir Kamal, Novitas Solutions, Inc. (J-H)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 04 2018

CERTIFIED MAIL

Bicker & Eckler Attorneys at Law
James F. Flynn, Esq.
100 South Third Street
Columbus, OH 43215-4291

CGS Administrators
Judith E. Cummings
Accounting Manager
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

RE: Marion General Hospital
Provider No. 36-0011
FYE 06/30/2010
PRRB Case No. 14-2911

Dear Mr. Flynn and Ms. Cummings

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

Background

On March 4, 2014, Marion General Hospital, the Provider, appealed an Original Notice of Program Reimbursement (NPR) dated September 4, 2013 for the fiscal year end ("FYE") June 30, 2010 cost reporting period. The Provider filed an individual appeal request (February 28, 2014) with the following issue:

1) The Provider desires to preserve the rights to obtain a shift of the calculation period of the DSH percentage from the federal fiscal year to the provider's cost report year, should such a shift be found to [be] desirable for the provider.

On January 1, 2015, The Medicare Contractor sent a letter to the Provider indicating its intent to reopen the FYE June 30, 2010 cost report.

The SSI Realignment issue is the sole issue that remains in the appeal, which is relevant to the jurisdictional challenge pending in the appeal.

Medicare Contractor's Contentions:

The Medicare Contractor filed a jurisdictional challenge on February 18, 2015 addressing the SSI Provider Specific issue (which it refers to as SSI Realignment).

The Medicare Contractor argues that the Board does not have jurisdiction over the SSI Realignment issue because the regulations do not allow Providers to file an appeal to reserve appeal rights. Furthermore, the Medicare Contractor argues that the appeal was premature because a final determination had not yet been made. The Medicare Contractor concludes that there is no final determination and the Board does not have jurisdiction over the issue.

Board's Decision

The Board finds that it does not have jurisdiction over the SSI Realignment issue.

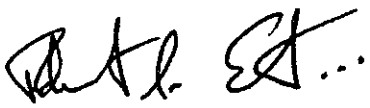
Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a hospital has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000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

Under 42 C.F.R. § 412.106(b)(3), addressing the calculation of 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 . . .." There is nothing in the record of this appeal to indicate that the Provider has requested realignment to the Provider's fiscal year end, nor is there anything indicating that the Medicare Contractor has made a final determination regarding this issue. Although there is evidence that a Notice of Intent to Reopen has been issued, there is no evidence of a Revised Notice of Program Reimbursement or final determination. The Board finds it does not have jurisdiction over the SSI Realignment issue as there is no final determination regarding this issue and the Provider has not met the dissatisfaction requirement for jurisdiction.

The SSI Realignment issue is dismissed and PRRB Case No. 14-2911 is hereby closed. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

FOR THE BOARD



Robert Evarts, Esq.
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

MAY 0 8 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**
17-1334G Southwest Consulting 2008 DSH Medicaid Fraction Part C Days Group
17-1333G Southwest Consulting 2008 DSH SSI Fraction Part C Days Group

Dear Mr. Newell:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' April 19, 2018 request[1] for expedited judicial review (EJR) (received April 23, 2018) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these appeals is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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[1] The EJR request referenced a third case, PRRB Case No. 17-0043G. The Board issued an EJR determination in that case on May 1, 2018.
[2] Providers' EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[23] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part

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

A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

Decision of the Board

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

Jurisdictional Determination

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

For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that ends on or before December 30, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[24] For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[25] The Board notes that the participant who filed a revised NPR appeal included within this EJR request was issued after August 21, 2008.

With respect to Provider # 1 Baystate Wing Hospital and Medical Center (provider number 22-0030) (Baystate Wing Hospital), the Provider filed an appeal from a revised NPR that did not adjust the SSI/Part C days issue as required for Board jurisdiction under 42 C.F.R. § 405.1889(b). Consequently, the Board does not have jurisdiction over Baystate Wing Hospital's appeal of the Part C days issue and hereby dismisses the Provider from both 17-1334G and 17-1333G, as they are a participant in both cases. Since jurisdiction over a Provider is

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

a prerequisite to granting a request for EJR, the Board denies Baystate Wing Hospital's request for EJR. *See* 42 C.F.R. § 405.1842(a).

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

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

[26] *See* 42 C.F.R. § 405.1837. If this was an individual appeal, the remaining Provider also meets the $10,000 amount in controversy for an individual appeal under 42 C.F.R. § 405.1835(a)(2).

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

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

Board Members Participating:

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

FOR THE BOARD:

Gregory H. Ziegler

Board Member

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

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

MAY 08 2018

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

RE: Community Health Systems Post 1498R 2006 SSI Data Match CIRP Group
CN 13-0605GC

Specifically:
Northwest Medical Center, 04-0138, FYE 10/31/2006, CN 16-2328
McKenzie Williamette Medical Center, 38-0020, FYE 12/31/2006, CN 16-1927
Sunbury Community Hospital, 39-0084, FYE 6/30/2006, CN 16-1936

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned group and the related individual appeals. We note that each of the Providers listed above appealed from a revised Notice of Program Reimbursement (RNPR) for a 2006 cost reporting period. The RNPRs were issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). The specific facts with regard to the issues in the individual appeals and the Board's jurisdictional determination are set forth below:

Pertinent Facts:

I. SSI Provider Specific Issue

One of the issues in these individual appeals is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. The Providers' issue description includes two components: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage (SSI Data Match) and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period (SSI Realignment).

There is a pending common issue related party (CIRP) group (case number 13-0605GC) for the SSI Data Match issue for FYE 2006. Upon review of the group, however, it is noted that none of the referenced commonly controlled Providers have transferred or directly appealed the SSI Data Match portion of the issue into group, case number 13-0605G.

II. Eligible Days Issue

McKenzie Williamette Medical Center and Sunbury Community Hospital also appealed the Medicaid Eligible Days issue from RNPRs. Both Providers contend that the Medicare Contractor ". . . failed to include all Medicaid eligible days, including . . . Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid

Percentage of the Medicare DSH calculation."[1] Both Providers indicated the issue was self-disallowed (S-D) and referenced audit adjustments 5 and 6 for the Medicaid Eligible Days issue.

For both Providers, audit adjustments 5 and 6 from the RNPRs relate to adjustments to the SSI Percentage and the DSH payment percentage on Worksheet E, Part A based on the hospitals' SSI percentages for cost reporting periods after 10/1/2005 and before 10/1/2006.

Board Determination:

I. SSI Provider Specific Issue

Pursuant to 42 C.F.R. 405.1837(b)(1)

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.

Based on this regulation, it is mandatory that the first aspect of the SSI Provider Specific issue -the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, be pursued in the SSI Data Match case.[2] Therefore, the Board hereby transfers the SSI Data Match component of the issue for the referenced Providers to the CIRP group, case number 13-0605GC.

The second aspect of the SSI Provider Specific issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, is hereby dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can appeal. As a result the Board finds that the appeal of this component of the issue is premature and dismisses it from the individual appeals.

II. Medicaid Eligible Days Issue

With regard to the Medicaid Eligible Days issue for McKenzie Williamette Medical Center and Sunbury Community Hospital (case numbers 16-1927 and 16-1936, respectively), the Board finds it lacks jurisdiction pursuant to 42 C.F.R. § 405.1889. This regulation states that any matter not specifically revised may not be considered in an appeal of the revised determination. In these cases, the evidence submitted does not support an adjustment to Medicaid Eligible Days on the RNPR for either Provider. Therefore, this issue is dismissed from case numbers 16-1927 and 16-1936.

After the transfer of the SSI Data Match component, the dismissal of the SSI Realignment component and the dismissal of the Medicaid Eligible Days issue from case numbers 16-1927 and 16-1936, there are no remaining issues in any of the individual appeals. Therefore case numbers 16-2328, 16-1927 and 16-

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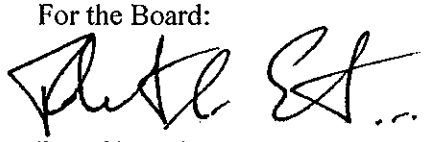
[1] *See* Providers' individual appeal requests at Tab 3, Issue 2.
[2] *See* Providers' Individual Appeal Requests at Tab 3, Issue 1 and Appeal Request in 13-0605GC.

1936 are closed and removed 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.

Please advise the Board whether the CIRP group, case 13-0605GC, can now be considered fully formed within 45 days of the date of this letter. If it is not yet complete, within the same time noted, identify the Providers for which you are still awaiting receipt of a final determination.

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

For the Board:



Board Member

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

cc: Byron Lamprecht, Wisconsin Physicians Service (J-5)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

MAY 08 2018

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

RE: Community Health Systems Post 1498R 2005 SSI Data Match CIRP Group
CN 16-1489GC

Specifically:
Wuesthoff Medical Center, 10-0291, FYE 9/30/2005, CN 17-0259
Riley Hospital, 25-0081, FYE 12/31/2005, CN 17-0422, CN 17-0483
Moberly Regional Medical Center, 26-0074, FYE 10/31/2005, CN 17-0484

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned group and the related individual appeals. We note that each of the Providers listed above appealed from a revised Notice of Program Reimbursement (RNPR) for a 2005 cost reporting period. The RNPRs were issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). The specific facts with regard to the issues in the individual appeals and the Board's jurisdictional determination are set forth below:

Pertinent Facts:

I. SSI Provider Specific Issue

The issue in these individual appeals is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue.[1] The Providers' issue description includes two components: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage (SSI Data Match) and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period (SSI Realignment).

There is a pending common issue related party (CIRP) group (case number 16-1489GC) for the SSI Data Match issue for FYE 2005. Upon review of the group, however, it is noted that none of the referenced commonly controlled Providers have transferred or directly appealed the SSI Data Match portion of the issue into group, case number 16-1489GC.

II. Eligible Days Issue

Riley Hospital and Moberly Regional Medical Center also appealed the Medicaid Eligible Days issue from RNPRs. Both Providers contend that the Medicare Contractor ". . . failed to include all Medicaid eligible days, including . . . Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid

[1] Case Nos. 17-0483 and 17-0484 also include the DSH Medicaid Eligible Days issue.

Percentage of the Medicare DSH calculation."[2] Both Providers indicated the issue was self-disallowed (S-D) and referenced audit adjustments 5 and 6 for the Medicaid Eligible Days issue.

For both Providers, audit adjustments 5 and 6 from the RNPRs relate to adjustments to the SSI Percentage and the DSH payment percentage on Worksheet E, Part A based on the hospitals' SSI percentages for cost reporting periods after 10/1/2004 and before 10/1/2005.

Board Determination:

I. SSI Provider Specific Issue

Pursuant to 42 C.F.R. 405.1837(b)(1)

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.

Based on this regulation, it is mandatory that the first aspect of the SSI Provider Specific issue -the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, be pursued in the SSI Data Match case.[3] Therefore, the Board hereby transfers the SSI Data Match component of the issue for the referenced Providers to the CIRP group, case number 16-1489GC.

The second aspect of the SSI Provider Specific issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, is hereby dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can appeal. As a result the Board finds that the appeal of this component of the issue is premature and dismisses it from the individual appeals.

II. Medicaid Eligible Days Issue

With regard to the Medicaid Eligible Days issue for Riley Hospital and Moberly Regional Medical Center (case numbers 17-0483 and 17-0484, respectively), the Board finds it lacks jurisdiction pursuant to 42 C.F.R. § 405.1889. This regulation states that any matter not specifically revised may not be considered in an appeal of the revised determination. In these cases, the evidence submitted does not support an adjustment to Medicaid Eligible Days on the RNPR for either Provider. Therefore, this issue is dismissed from case numbers 17-0483 and 17-0484.

After the transfer of the SSI Data Match component, the dismissal of the SSI Realignment component and the dismissal of the Medicaid Eligible Days issue from case numbers 17-0483 and 17-0484, there are no remaining issues in any of the individual appeals. Therefore case numbers 17-0259, 17-0483 and 17-

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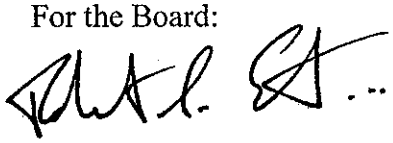
[2] *See* Providers' individual appeal requests at Tab 3, Issue 2.
[3] *See* Providers' Individual Appeal Requests at Tab 3, Issue 1 and Appeal Request in 16-1489GC.

0484 are closed and removed 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.

Please advise the Board whether the CIRP group, case 16-1489GC, can now be considered fully formed within 45 days of the date of this letter. If it is not yet complete, within the same time noted, identify the Providers for which you are still awaiting receipt of a final determination.

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

For the Board:



Board Member

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

cc: Mounir Kamal, Novitas Solutions, Inc. (J-H)
Geoff Pike, First Coast Service Options, Inc. (J-N)
Byron Lamprecht, Wisconsin Physicians Service (J-5)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

MAY 0 8 2018

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

RE: Community Health Systems Post 1498R 2006 SSI Data Match CIRP Group
CN 13-0605GC

Specifically:
Northwest Regional Medical Center, 26-0022, FYE 05/31/2006, CN 17-0055
Dallas Regional Medical Center, 45-0688, FYE 12/31/2006, CN 16-2251
Brownwood Regional Medical Center, 45-0587, FYE 9/30/2006, CN 16-2237
Stringfellow Memorial Hospital, 01-0038, FYE 6/30/2006, CN 16-2529
Riverview Regional Medical Center, 01-0046, FYE 6/30/2006, CN 16-2528
Lancaster Regional Medical Center, 39-0061, FYE 6/30/2006, CN 16-2347
Lake Norman Regional Medical Center, 34-0129, FYE 9/30/2006, CN 16-1958
Davis Regional Medical Center, 34-0144, FYE 9/30/2006, CN 16-1957
Carolina Pines Regional Medical Center, 42-0010, FYE 9/30/2006, CN 16-1968
Merit Health Care, 25-0072, FYE 3/31/2006, CN 17-0422

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned group and the related individual appeals. We note that each of the Providers listed above appealed from a revised Notice of Program Reimbursement (RNPR) for a 2006 cost reporting period. The RNPRs were issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). The specific facts with regard to the issues in the individual appeals and the Board's jurisdictional determination are set forth below:

Pertinent Facts:

I. SSI Provider Specific Issue

The sole issue in these individual appeals (except case number 17-0422 – which also includes Eligible Days) is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. The Providers' issue description includes two components: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage (SSI Data Match) and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period (SSI Realignment).

There is a pending common issue related party (CIRP) group (case number 13-0605GC) for the SSI Data Match issue for FYE 2006. Upon review of the group, however, it is noted that none of the referenced commonly controlled Providers have transferred or directly appealed the SSI Data Match portion of the issue into the group, case number 13-0605GC.

II. Eligible Days Issue

As noted, Merit Health Central (case number 17-0422) also appealed the Medicaid Eligible Days issue from an RNPR. The Provider contends that the Medicare Contractor ". . . failed to include all Medicaid eligible days, including . . . Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation."[1] The Provider referenced audit adjustments 5 and 6 for this issue. Audit adjustments 5 and 6 from the RNPR relate to adjustments to the SSI percentage and the DSH payment percentage on Worksheet E, Part A based on the hospitals' SSI percentages for cost reporting periods after 10/1/2004 and before 10/1/2005.

Board Determination:

I. SSI Provider Specific Issue

Pursuant to 42 C.F.R. 405.1837(b)(1)

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations or CMS Rulings tht is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.

Based on this regulation, it is mandatory that the first aspect of the SSI Provider Specific issue -the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, be pursued in the SSI Data Match case.[2] Therefore, the Board hereby transfers the SSI Data Match component of the issue for the referenced Providers to the CIRP group, case number 13-0605GC.

The second aspect of the SSI Provider Specific issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, is hereby dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can appeal. As a result the Board finds that the appeal of this component of the issue is premature and dismisses it from the individual appeals.

II. Medicaid Eligible Days Issue

With regard to the Medicaid Eligible Days issue for Merit Health Care (case number 17-0422), the Board finds it lacks jurisdiction pursuant to 42 C.F.R. § 405.1889. This regulation states that any matter not specifically revised may not be considered in an appeal of the revised determination. In this case, the evidence submitted does not support an adjustment to Medicaid Eligible Days on the RNPR. Therefore, this issue is dismissed from case number 17-0422.

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[1] *See* Provider's Individual appeal request at Tab 3, Issue 2.
[2] *See* Providers' Individual Appeal Requests at Tab 3, Issue 1 and Appeal Request in 13-0605GC.

After the transfer of the SSI Data Match component, the dismissal of the SSI Realignment component and the dismissal of the Medicaid Eligible Days issue from case number 17-0422, there are no remaining issues in any of the individual appeals. Therefore case numbers 17-0055, 16-2251, 16-2237, 16-2529, 16-2528, 16-2347, 16-1958, 16-1957, 16-1968 and 17-0422 are closed and removed 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.

Please advise the Board whether the CIRP group, case 13-0605GC, can now be considered fully formed within 45 days of the date of this letter. If it is not yet complete, within the same time noted, identify the Providers for which you are still awaiting receipt of a final determination.

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

For the Board:

Board Member

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

cc: Byron Lamprecht, Wisconsin Physicians Service (J-5)
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

MAY 0 8 2018

CERTIFIED MAIL

Kimberly Blanquart
Vice President of Reimbursement & Rev Optimization
Mercy Health
645 Maryville Center, Suite 100
St. Louis, MO 63141

RE: **Dismissal of Group Appeal**
Group Name: Mercy Health 2018 Understatement of Documentation and Coding Repayment Adjustment CIRP Group
PRRB Case Number: 18-1038GC

Dear. Ms. Blanquart:

The Provider Reimbursement Review Board (Board) is in receipt of Mercy Health's request to establish a Common Issue Related Party (CIRP) group appeal for fiscal year 2018 addressing the understatement of documentation and coding repayment adjustment issue pursuant to 42 C.F.R. § 405.1835(a)(3).

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to participate in a group appeal before the Board if it is dissatisfied with a final determination, the total amount in controversy for the group is $50,000 or more and the hearing request is received by the Board within 180 days of the date of receipt of the final determination by the provider, unless the provider qualifies for a good cause extension pursuant to 42 C.F.R. § 405.1835(a)(3). When an appeal is filed from a Notice of Program Reimbursement (NPR), there is an additional five-day presumption for mailing to determine the presumed date of receipt of the NPR. However, when an appeal is filed from a Federal Register notice, the five-day presumption for mailing is not applicable because the Federal Register is publicly available and is not mailed. In accordance with 42 C.F.R. § 405.1801(a) and PRRB Rule 21, the date of filing is the date of receipt by the Board or the date of delivery by a nationally-recognized next-day courier.

The final determination being appealed is the August 14, 2017 Federal Register, and 180 days from the date of that publication is Saturday, February 10, 2017. The Federal Rules of Civil Procedure state that "if the last day is a Saturday, Sunday, or legal holiday, the period continues to run until the end of the next day that is not a Saturday, Sunday, or legal holiday."[1] Based on this procedure, the appeal was due to the Board on Monday, February 12, 2018.

[1] FED.R.CIV.P. 6(a)(1)(c).

On February 7, 2018, Mercy Health sent out a CIRP group appeal request via Federal Express (the cover letter was dated February 6, 2018). Although the cover letter contained the correct address for the Board, the Federal Express package was addressed to PRRB Appeals at Federal Specialized Services (FSS), the Appeals Support Contractor. The Federal Express tracking receipt shows that FSS received the filing at 9:30 a.m. on Thursday, February 8, 2018. Upon receipt of the Federal Express delivery confirmation, Mercy Health would have been aware that the package was delivered to Illinois instead of Maryland. Mercy Health had the opportunity to rectify the address error and timely file the group appeal at the Board, however, the hearing request was not reissued until March 5, 2018, almost one month later. The Board received Mercy Health's hearing request on March 6, 2018, which is 204 days after the issuance of the Federal Register publication and exceeding the 180-day time frame for filing an appeal with the Board.

The regulation at 42 C.F.R. § 405.1836(b) explains when the Board may find good cause to extend the time for filing. The regulation states in pertinent part:

> (a) A request for a Board hearing that the Board receives after the applicable 180-day time limit prescribed in § 405.1835(a)(3) or § 405.1835(c)(2) must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider.
>
> (b) The Board may find good cause to extend the time limit only if the provider demonstrates in writing it [could] not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3).

The Board Rules provide additional guidance. PRRB Rule 5.2 states that "[t]he representative is responsible for . . . meeting the Board's deadlines. . . . Failure of a representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines." In addition, PRRB Rule 46.3 proclaims that "[u]pon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight . . . will not be considered good cause to reinstate." In the present case, the untimely filing of the group appeal is a result of administrative oversight, which is not a valid basis to grant a good cause exception. Furthermore,

had Mercy Health acted promptly to rectify the incorrect mailing address, the appeal request would have arrived at the Board in a timely manner.

The Board finds that the group appeal was not timely filed within 180 days of the Federal Register publication and the justification presented for the untimely filing does not rise to the level of a good cause extension of the time limit to file an appeal. As the appeal does not meet the regulatory filing requirements, the Board hereby dismisses Case No. 18-1038GC.

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

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Charlotte F Benson

Board Member

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 0 8 2018

CERTIFIED MAIL

Toyon Associates, Inc.
Christine Ponce
Director – Client Services
1800 Sutter Street – Suit 600
Concord, CA 94520-2546

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

RE: Laguna Honda Hospital & Rehabilitation Center
Provider No.: 05-0668
FYEs: 6/30/11
PRRB Case Nos.: 15-0184

Dear Ms. Ponce and Ms. Frewert,

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

Background

The Provider submitted a request for hearing on October 21, 2014, based on a Notice of Program Reimbursement ("NPR") dated April 28, 2014. The hearing request included six issues as follows:

1) Issue No. 1 – Medicare Settlement Data (Including Outlier Payments);
2) Issue No. 2 – Medicare Low Income Patient (LIP) Payments – Additional Medicaid Eligible Days;
3) Issue No. 3 – Medicare Low Income Patient (LIP) Payments – Inclusion of Medicare Dual Eligible Part A Days in the SSI Ratio Issued August 23, 2012;
4) Issue No. 4 – Medicare Low Income Patient (LIP) Payments – Inclusion of Medicare Dual Eligible Part C Days in the SSI Ratio Issued August 23, 2012; and
5) Issue No. 5 – Medicare Low Income Patient (LIP) Payments – Accuracy of CMS Developed SSI Ratio Issued August 23, 2012

The Provider submitted a request dated September 28, 2015 to transfer the Outlier Payments portion of Issue No. 1 to PRRB Case No. 15-2806G – Toyon 2011 Understatement of Outlier Payments Group. Subsequently, the Provider submitted requests dated April 10, 2018 and April 16, 2018 to transfer Issue No. 2 to PRRB Case No. 18-1170G - Toyon 2011 LIP Inclusion of Additional Medicaid Eligible Days to Medicaid Ratio Group, Issue No. 3 to PRRB Case No. 18-0058G - Toyon 2011 LIP Inclusion of Medicare Part A Unpaid Days in SSI Ratio Group, Issue No. 4 to PRRB Case No. 18-0057G - Toyon 2011 LIP Inclusion of Medicare Part C Days in SSI Ratio Group, and Issue No. 5 to PRRB Case No. 18-0056G - Toyon 2011 LIP Accuracy of CMS Developed SSI Ratio Group.

The Medicare Contractor submitted a jurisdictional challenge on the Outlier Payments portion of Issue No. 1 and all of the LIP issues in the appeal on September 10, 2015.[1] The Provider submitted a jurisdictional response on September 30, 2015.

Medicare Contractor's Position

The Medicare Contractor contends that the language of 42 U.S.C. § 1395ww(j)(8)(B)[2] prohibits and precludes administrative and judicial review of the IRF-PPS rates established under 42 U.S.C. § 1395ww(j)(3)(A). The Medicare Contractor maintains that, because the IRF-PPS rate is comprised of both the general federal rate based on historical costs and adjustments to that federal rate (including but not limited to the LIP adjustment at issue), the statute prohibits administrative and judicial review of the LIP adjustment. Accordingly, the Medicare Contractor argues that the Board is divested of jurisdiction to hear the Provider's appeal because it must comply with all of the provisions of the Medicare Act and the regulations issued thereunder.[3]

Provider's Position

The Provider contends that the NPR issued on April 28, 2014 constitutes a final determination by the Medicare Contractor with respect to the provider's cost report. In 42 C.F.R. § 405.1801(a)(2), it defines a final determination as follows: "An intermediary determination is defined as a "determination of the total amount of payment due to the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period..."[4]

The Provider contends that the Medicare Contractor made an adjustment that revised the IRF Medicaid Eligible Days from 496 to 512 per audit adjustment number 5. In addition, the Medicare Contractor made an adjustment to remove the as-filed IRF protested amount totaling $14,107 per audit adjustment number 23, which includes protested amounts for the following LIP payment issues: (a) Understated LIP payments due to an understatement of the SSI ratio as published by CMS; (b) Understated LIP payments due to CMS policy of excluding Medicare/Medicaid dual eligible Part A days; (c) Understated LIP payments due to CMS policy of excluding Medicare/Medicaid Part C days; (d) Understated LIP payments due to the exclusion of Code 2 & 3 Medicaid days without an aid code returned from the State of California Medicaid Eligibility Branch and (e) Understated LIP payments pending receipt of California Medicaid eligibility verification. The Provider argues that the Medicare Contractor did indeed post audit adjustments that resulted in a change to the Provider's reported LIP entitlement in the Medicare cost report which thereby allows the Provider an avenue to pursue a correction to their LIP entitlement via the PRRB appeal process.[5]

---

[1] The challenge to the Outlier Payments aspect of Issue No. 1 will be addressed in the group appeal. The Provider did not brief the Medicare Settlement Data – Additional Claims aspect of Issue No. 1 in its Preliminary Position Paper submitted on June 26, 2015. As such, the Board considers that issue to be abandoned.

[2] Formerly designated at paragraph (7). Section 3004(b) of the Affordable Care Act addressed the IRF PPS program and reassigned the previously-designated section 1886(j)(7) of the Act [42 U.S.C. § 1395ww(j)(7)] to section 1886(j)(8) [42 U.S.C. § 1395ww(j)(8)] and inserted a new section 1886(j)(7), which contains new requirements for the Secretary to establish a quality reporting program for IRFs.

[3] 42 C.F.R. § 405.1867.

[4] Provider's jurisdictional response at 2 (Emphasis included).

[5] Provider's jurisdictional response at 4.

The Provider contends that the LIP adjustment is not a component of the IRF-PPS rate described in § 1395ww(j)(3)(A) (*i.e.*, the unadjusted federal rates) because LIP is calculated as a current cost reporting period add-on payment to the IRF-PPS federal payment and it is reported on a separate line within the Medicare cost report.[6] The Provider argues that it is only disputing the accuracy of the provider-specific data elements used by the Medicare Contractor, not the establishment or methodology for development of the federal IRF prospective payments.[7] The Provider contends that § 1395ww(j)(8) does not prohibit its challenge as to whether CMS and its agents utilized the proper data elements in executing that formula. The Provider maintains that, while § 1395ww(j)(8) prohibits administrative or judicial review for certain aspects of the establishment of the IRF payments, there is no specific language within § 1395ww(j)(8) prohibiting administrative or judicial review as it pertains to the establishment of LIP.[8]

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 LIP issues in this appeal as the NPR was issued on April 28, 2014, after the October 1, 2013 effective date of the regulatory revision to 42 C.F.R. § 412.630 that precludes Board review of the LIP adjustment.

In reviewing the LIP issues in this appeal, the Board first looked to the statutory provision prohibiting certain judicial and administrative review. 42 U.S.C. § 1395ww(j)(8) specifies:

> There shall be no administrative or judicial review . . . of the *establishment* of—
>
> (A) case mix groups, of the methodology for the classification of patients within such groups, and the appropriate weighting factors thereof under paragraph (2),
>
> (B) the prospective payment rates under paragraph (3),
>
> (C) outlier and special payments under paragraph (4), and
>
> (D) area wage adjustments under paragraph (6).[9]

[6] Provider's jurisdictional response at 5.
[7] Provider's jurisdictional response at 5.
[8] Provider's jurisdictional response at 6.
[9] (Emphasis added).

The Secretary adopted a regulation limiting administrative and judicial review which mirrors the statutory limitations, specifically limiting review only to the "unadjusted" Federal payment rate. For the years prior to these appeals, 42 C.F.R. § 412.630 stated:

> Administrative or judicial review under 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factor, the *unadjusted* Federal per discharge payments rates, additional payments for outliers and special payments, and the area wage index.[10]

Significantly, the term "the unadjusted Federal rate" is defined in 42 C.F.R. § 412.624(c) and it does not include any of the adjustments discussed in § 412.624(e), including the LIP adjustment.

The Board finds that in the August 2013 Inpatient Rehabilitation Facility Prospective Payment System ("IRF PPS") Final Rule, the Secretary expanded the list of adjustments in § 412.630 to include the LIP adjustment. CMS stated in the Final Rule:

> Our intent was to honor the full breadth of the preclusion of administrative or judicial review provided by section 1886(j)(8) of the Act. However, the regulatory text reflecting the preclusion of review has been at times improperly interpreted to allow review of adjustments authorized under section 1886(j)(3)(v) of the Act. Because we interpret the preclusion of review at § 1886(j)(8) of the Act to apply to all payments authorized under section 1886(j)(3) of the Act, we do not believe that there should be administrative or judicial review of any part of the prospective rate. Accordingly, we are clarifying our regulation at § 412.630 by deleting the word "unadjusted" so that the regulation will clearly preclude review of the "Federal per discharge payment rates."[11]

During the period at issue, the Board finds that the revised regulation precluded review of the LIP adjustment. In this regard, the Board concludes that the regulatory changes made in the August 2013 Final Rule are applicable to this appeal because they were effective on October 1, 2013. As such, the Board concludes that it does not have jurisdiction over the LIP issues (Issue Nos. 2, 3. 4 and 5) in this appeal, and dismisses them from the appeal. Additionally, the Board denies the transfers of the LIP issues to group appeals.

As no issues remain in the appeal, the Board closes the case 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:
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.

FOR THE BOARD

Charlotte F Benson

Board Member

[10] (emphasis added)
[11] 78 Fed. Reg. at 47900.

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 0 8 2018

CERTIFIED MAIL

Paul A. Beaudoin
Vice President of Finance
Day Kimball Healthcare
320 Pomfret Street
Putnam, CT 06260

Re: **Dismissal of Appeal**
Provider Name: Day Kimball Hospital
Provider Number: 07-0003
FYE: 9/30/2018
PRRB Case Number: 18-1041

Dear Mr. Beaudoin:

The Provider Reimbursement Review Board (Board) is in receipt of Day Kimball Healthcare's request to establish an individual appeal for Day Kimball Hospital (Day Kimball or Provider) for fiscal year ending September 30, 2018.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to participate in an individual appeal before the Board if it is dissatisfied with a final determination, the total amount in controversy is $10,000 or more and the hearing request is received by the Board within 180 days of the date of receipt of the final determination by the provider, unless the provider qualifies for a good cause extension pursuant to 42 C.F.R. § 405.1835(a)(3). When an appeal is filed from a Notice of Program Reimbursement (NPR), there is an additional five-day presumption for mailing to determine the presumed date of receipt of the NPR. However, when an appeal is filed from a Federal Register notice, the five-day presumption for mailing is not applicable because the Federal Register is publicly available and is not mailed. In accordance with 42 C.F.R. § 405.1801(a) and PRRB Rule 21, the date of filing is the date of receipt by the Board or the date of delivery by a nationally-recognized next-day courier.

The final determination being appealed is the August 14, 2017 Federal Register, and 180 days from the date of that publication is Saturday, February 10, 2017. The Federal Rules of Civil Procedure state that "if the last day is a Saturday, Sunday, or legal holiday, the period continues to run until the end of the next day that is not a Saturday, Sunday, or legal holiday."[1] Based on this procedure, the appeal was due to the Board on Monday, February 12, 2018.

[1] FED.R.CIV.P. 6(a)(1)(c).

On February 7, 2018, Day Kimball Hospital sent out its individual appeal request via Federal Express (the cover letter was dated February 6, 2018). Although the cover letter contained the correct address for the Board, the Federal Express package was addressed to PRRB Appeals at Federal Specialized Services (FSS), the Appeals Support Contractor. The Federal Express tracking receipt shows that FSS received the filing at 9:32 a.m. on Thursday, February 8, 2018. Upon receipt of the Federal Express delivery confirmation, Day Kimball would have been aware that the package was delivered to Illinois instead of Maryland. Day Kimball had the opportunity to rectify the address error and timely file its individual appeal at the Board, however, the hearing request was not reissued until March 7, 2018, almost one month later. The Board received the Provider's hearing request on Thursday, March 8, 2018, 206 days after the issuance of the Federal Register publication and exceeding the 180-day time frame for filing an appeal with the Board.

The regulation at 42 C.F.R. § 405.1836(b) explains when the Board may find good cause to extend the time for filing. The regulation states in pertinent part:

> (a) A request for a Board hearing that the Board receives after the applicable 180-day time limit prescribed in § 405.1835(a)(3) or § 405.1835(c)(2) must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider.
>
> (b) The Board may find good cause to extend the time limit only if the provider demonstrates in writing it [could] not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3).

The Board Rules provide additional guidance. PRRB Rule 5.2 states that "[t]he representative is responsible for . . . meeting the Board's deadlines. . . . Failure of a representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines." In addition, PRRB Rule 46.3 proclaims that "[u]pon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight . . . will not be considered good cause to reinstate." In the present case, the untimely filing of the appeal is a result of administrative oversight, which is not a valid basis to grant a good cause exception. Furthermore, had the

Provider acted promptly to rectify the incorrect mailing address, the appeal request would have arrived at the Board in a timely manner.

The Board finds that the individual appeal was not timely filed within 180 days of the Federal Register publication. As the appeal does not meet the regulatory filing requirements and the justification presented for the untimely filing does not rise to the level of a good cause extension of the time limit to file an appeal, the Board hereby dismisses Case No. 18-1041.

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

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Charlotte F Benson

Board Member

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 10 2018

CERTIFIED MAIL

Ken Janowski
Vice President
Strategic Reimbursement Group, LLC
16408 E. Jacklin Dr.
Fountain Hills, AZ 85268

Re: **Dismissal of Appeal**
Provider Name: Central Valley General Hospital
Provider Number: 05-0196
FYE: 12/31/2013
PRRB Case Number: 18-0162

Dear Mr. Janowski:

The Provider Reimbursement Review Board (Board) is in receipt of Adventist Health's request to establish an individual appeal for Central Valley General Hospital (Provider) for fiscal year ending December 31, 2013.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to participate in an individual appeal before the Board if it is dissatisfied with a final determination, the total amount in controversy is $10,000 or more and the hearing request is received by the Board within 180 days of the date of receipt of the final determination by the provider, unless the provider qualifies for a good cause extension pursuant to 42 C.F.R. § 405.1835(a)(3). When an appeal is filed from a Notice of Program Reimbursement (NPR), there is an additional five-day presumption for mailing to determine the presumed date of receipt of the NPR. However, when an appeal is filed from a Federal Register notice, the five-day presumption for mailing is not applicable because the Federal Register is publicly available and is not mailed. In accordance with 42 C.F.R. § 405.1801(a) and PRRB Rule 21, the date of filing is the date of receipt by the Board or the date of delivery by a nationally-recognized next-day courier.

The regulation at 42 C.F.R. § 405.1836(b) explains when the Board may find good cause to extend the time for filing. The regulation states in pertinent part:

> (a) A request for a Board hearing that the Board receives after the applicable 180-day time limit prescribed in § 405.1835(a)(3) or § 405.1835(c)(2) must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider.

> (b) The Board may find good cause to extend the time limit only if the provider demonstrates in writing it [could] not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3).

The Board Rules provide additional guidance. PRRB Rule 5.2 states that "[t]he representative is responsible for . . . meeting the Board's deadlines. . . . Failure of a representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines." In addition, PRRB Rule 46.3 proclaims that "[u]pon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight . . . will not be considered good cause to reinstate."

In June 2017, the Board moved its office to a new location. In light of the upcoming move, ALERT 12 – CHANGE OF ADDRESS was released on June 7, 2017 via an e-mail blast to all contacts in the Board's Casetracker system. Alert 12 informed all parties that effective June 19, 2017, all filings should be sent to the Board's new address located on Woodlawn Drive.

Noridian Healthcare Solutions (the Medicare Contractor) issued the Provider's NPR on April 20, 2017. The 185th day fell on Sunday, October 22, 2017. The Federal Rules of Civil Procedure state that "if the last day is a Saturday, Sunday, or legal holiday, the period continues to run until the end of the next day that is not a Saturday, Sunday, or legal holiday."[1] Based on this procedure, the appeal was due to the Board on Monday, October 23, 2017. However, the appeal was not received at the Board until October 30, 2017, which is 193 days after the issuance of the NPR. This exceeds the 180-day time frame (including the five day presumption) for filing an appeal with the Board.

Upon review, it is noted that Adventist Health sent the individual appeal request to the Board's previous address. Although the initial cover letter was dated October 10, 2017, the tracking information retrieved from the United Postal Service (UPS) website revealed that the package was picked up on October 13, 2017 for UPS 3 Day Select service, and delivery was attempted on October 16, 2017. Further review of the UPS tracking status indicated that the receiver had moved and UPS was attempting to obtain a new delivery address. Had the delivery status been monitored, Adventist

[1] FED.R.CIV.P. 6(a)(1)(c).

Health would have been aware of the attempted delivery and would have had the opportunity to rectify the incorrect address and timely file its individual appeal at the Board. However, UPS did not locate a new delivery address and the package was sent back to California where it was returned to the shipper on October 27, 2018.

The Board finds that the individual appeal was not timely filed within 185 days of the date of the NPR. The untimely filing of the appeal is a result of administrative oversight, which is not a valid basis to grant a good cause exception. Furthermore, had the UPS tracking status been monitored, Adventist Health would have been aware of the address error notification on October 16, 2017 and intervened in order for the appeal request to arrive at the Board in a timely manner. As the appeal does not meet the regulatory filing requirements and the justification presented for the untimely filing does not rise to the level of a good cause extension of the time limit to file an appeal, the Board hereby dismisses Case No. 18-0162.

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

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Board Member

cc: Evaline Alcantara, Noridian Healthcare Solutions
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

MAY 16 2018

Case No. 13-2247

Certified Mail

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

Re: UHHS/Richmond Heights (36-0075)
FYE 12/31/2006

Dear Ms. Goron:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in Case No. 13-2247. The Medicare Contractor, CGS Administrators ("Contractor" or "CGS"), challenged the Board's jurisdiction over UHHS/Richmond Heights' ("Provider" or "Richmond") entire case due to multiple reasons. The Board hereby determines that it grants jurisdiction in part and denies jurisdiction in part. Case No. 13-2247 will close based on the Board's decision, as outlined below.

Background

Richmond filed an appeal with the Board based on its 11/28/2012 revised Notice of Program Reimbursement ("RNPR") for fiscal year end 12/31/2006.[1] Richmond appealed the following disproportionate share hospital ("DSH")[2] issues:

(1) SSI (Systemic Errors): Whether the Secretary properly calculated the DSH supplemental security income percentage ("SSI%")
(2) SSI (Provider Specific): Whether the Contractor used the correct SSI%
(3) Medicaid Eligible ("ME") Days: Whether the Contractor properly excluded ME Days
(4) Part C Days: Whether Part C Days were properly accounted for, arguing that the days should be included in the DSH Medicaid fraction ("Medicaid%") and not the SSI%
(5) Dual Eligible ("DE") Days: Whether DE Days should be in the Medicaid%[3]

[1] Richmond Appeal Request, May 28, 2013.
[2] DSH is composed of 2 fractions, one is the Medicare or SSI fraction and the second is the Medicaid fraction. *See* 42 C.F.R. § 412.106 (2012).
[3] Appeal Request Tab 3.

Richmond indicated that it was appealing from an original NPR; however, the documents show that it was actually appealing from an RNPR. Richmond failed to include all of the related RNPR documents; however, the RNPR's Audit Adjustment Report, which was included, showed that the SSI% was adjusted to "updated CMS amounts and to update DSH . . . accordingly."[4] Richmond stated that the amount in controversy for these issues is $70,841.00.[5]

Richmond submitted multiple Transfer Requests to transfer the following issues to group cases:

(1) SSI% to Case No. 14-1770GC
(2) Part C Days [exclude from] SSI% to Case No. 14-1767GC
(3) Part C Days [include in] Medicaid% to Case No. 14-1766GC
(4) DE Days [exclude from] SSI% to Case No. 14-1769GC
(5) DE Days [include in] Medicaid% to Case No. 14-1768GC[6]

Due to the multiple transfer requests, Richmond only briefed ME Days and SSI (Provider Specific) in its Preliminary Position Paper.[7]

The Contractor filed a Jurisdictional Challenge, submitting that the Board lacks jurisdiction over the entire case.[8] CGS asserts that the Board lacks jurisdiction because (1) the appeal request was for an RNPR, but the Provider did not submit the documentation required for an RNPR appeal; (2) CGS did not make an audit adjustment to all of the issues in the appeal; and, (3) Richmond has multiple components combined into one issue, which goes against Board Rules.[9] CGS contends that since the RNPR was reopened to revise the SSI% only, the appeal may only address issues specific to the SSI%.[10] CGS states that no adjustment was made to ME Days or the Medicaid%; therefore, certain issues are beyond the scope of the RNPR.[11] CGS requests that the Board dismiss this case.[12]

In Richmond's Jurisdictional Response, it states that the Board has jurisdiction over the appeal because there were adjustments to DSH, which is enough to warrant Board jurisdiction over the issues in this appeal.[13] Richmond further contends, however, that an adjustment is not required at all, and a presentment requirement does not apply to this case.[14] Richmond argues that the same analysis that the Supreme Court made in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) applies here.[15] Richmond writes:

> The [Contractor] did adjust the Provider's DSH calculation based on the publishing of the new DSH/SSI percentages and included DSH/Managed Care Part C Days ("Part C Days") and DSH/Dual Eligible

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[4] Appeal Request Model Form A at 3.
[5] Appeal Request at 2.
[6] *See* Richmond Model Form D Transfer Requests, Jan. 15, 2014.
[7] Richmond's Preliminary Position Paper Letter to the Board, Jan. 31, 2014. The Board notes that Richmond originally filed proof of its Preliminary Position Paper on January 23, 2014; however, it filed an Amended Preliminary Position Paper on January 31, 2014 because it failed to brief ME Days in its first paper.
[8] CGS Jurisdictional Challenge, May 13, 2014.
[9] Jurisdictional Challenge at 1.
[10] *Id.* at 4-6.
[11] *Id.*
[12] *Id.* at 7.
[13] Richmond's Jurisdictional Response at 1, Jun. 13, 2014.
[14] Jurisdictional Response at 1.
[15] *Id.* at 4-5.

> Days (Medicare Part A Exhausted Benefits (EB), Medicare Secondary Payor (MSP), and No Pay Part A Days) ("Dual Eligible Days") in the Medicare (SSI) fraction. Accordingly, the Provider is dissatisfied with its[] SSI ratio because of the inclusion of both Part C and Dual Eligible Days and requests that these Days be excluded. In addition, as the 2004 Final IPPS Rule, which required the inclusion of Part C Days in the SSI (Medicare) fraction, was invalidated by the D.C. Circuit in *Allina Health Servs. v. Sebelius*, ("*Allina*"), [Richmond] contends that the Part C Days must be excluded from the Medicare fraction of the DSH calculation. Further, since the Court indicated that Part C Days must be in one fraction or the other, the Provider contends that these Days must be included in the Medicaid fraction of the DSH calculation.[16]

For these reasons, Richmond requests that the Board grant jurisdiction over its appeal. Richmond also states it withdraws its ME Days issue.[17]

Board Determination

A provider is entitled to a hearing before the Board if (1) such provider is dissatisfied with a final determination of the Medicare Contractor as to its amount of total program reimbursement due the provider; (2) the amount in controversy is $10,000 or more; and, (3) such provider files a request for a hearing within 180 days after notice of the final determination.[18] The Board finds that Richmond timely filed its appeal and meets the amount in controversy requirement. The Board also finds that Richmond appealed from an RNPR, which has more stringent appeal rules. The regulation that applies to these revised determinations states:

> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.[19]

The regulation governing RNPR appeals limits an appeal to only those items revised upon reopening. The Board finds that Richmond's RNPR "specifically revised" Richmond's SSI%, which updated its DSH payment.

The Board finds that the arguments Richmond makes in its Jurisdictional Response fail for multiple reasons. First, the *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) rationale is not applicable here. In *Bethesda*, the Supreme Court held that a provider is not required to claim an item on its cost report if it would be futile to claim because the provider is barred from doing so by statute, rule, or regulation. These claims are known as "self-disallowed" costs. Richmond states that, in *Bethesda*, the Supreme Court concluded that, "[t]he strained interpretation offered by the Secretary [that dissatisfied necessarily incorporates an exhaustion requirement [(i.e., a provider must claim the item on its cost report in order to appeal that item)]] is inconsistent with the express language of

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[16] *Id.*
[17] *Id.* at 6.
[18] 42 U.S.C. § 1395oo(a).
[19] 42 C.F.R. § 405.1889(b) (2012).

the statute."[20] Richmond states that, since the language of 42 U.S.C. § 1395oo(a) has not changed since that decision, *Bethesda* still holds today, and Richmond may appeal a self-disallowed cost even if it failed to first present its claim to the Contractor.[21] However, the *Bethesda* ruling concerned an *original* NPR and does not take into account the rules regarding appeals from a *revised* NPR. In this case, Richmond is required to have a specific revision to the item under appeal.

Second, it is not true that any adjustment to DSH allows Richmond to appeal all of the components of DSH. In fact, Board Rule 8 provides authority for framing issues for adjustments involving multiple components.[22] Board Rule 8.1 states:

> Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7.[23]

The Board Rules use DSH as a common example of an issue with multiple components. DSH appeals must be broken down into specific issues or components. The Board Rules, therefore, contradict Richmond's argument that any adjustment to DSH provides a jurisdictionally valid appeal for all of its components.

This reasoning was upheld in *Emanuel Medical Center, Inc. v. Sebelius*, No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014). The court held that the "issue-specific" interpretation of the RNPR regulation (42 C.F.R. § 405.1889, cited above) is reasonable and that any change to DSH is not sufficient to establish that all of the elements of DSH have been reconsidered. The Board Rules and regulations dictate that what was specifically revised in the RNPR is dispositive in determining appeal rights. Here, the Contractor adjusted Richmond's SSI%, but not its Medicaid%. Therefore, the Board may only grant jurisdiction for issues related to Richmond's SSI%.

Richmond defines the SSI (Provider Specific) issue as whether the Secretary properly calculated the SSI%. Similarly, Richmond defines SSI (Systemic Errors) as whether the Contractor used the correct SSI%. The Board finds that these are the same issue since the Contractor is required to use the SSI% provided by the Secretary. The Board hereby grants jurisdiction over SSI (Systemic Errors) and grants the transfer of this issue to Case No. 14-1770GC. The Board hereby dismisses SSI (Provider Specific) as duplicative (the same issue cannot be in more than one appeal).[24]

The Board also notes that, in its Appeal Request, Richmond writes in its SSI (Provider Specific) description that, "[t]he Provider also hereby preserves its right to request under separate cover that CMS recalculate the [SSI%] based upon the Provider's cost reporting period."[25] This is also known as "SSI Realignment." The Board finds that, in order to obtain an SSI Realignment, the Provider must first request it from the Contractor. There is no evidence that Richmond made any such request. Therefore, the Board dismisses "SSI Realignment" since there is no final determination from which the Provider is appealing.

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[20] Jurisdictional Response at 5.
[21] *Id.*
[22] *See* Board Rule 8 at 7, Jul. 1, 2009.
[23] Board Rule 8.1 at 7.
[24] *See* Board Rule 4.5 at 3 ("A Provider may not appeal an issue from a final determination in more than one appeal.").
[25] Appeal Request Tab 3 at 9.

Richmond also appealed the exclusion of Part C Days from the SSI% and the inclusion of Part C Days in the Medicaid%. It requested to transfer both of these issues to different group appeals. As a result of the Board's finding that only the SSI% was revised in Richmond's RNPR, the Board grants jurisdiction over the exclusion of Part C Days from the SSI% and grants the transfer of this issue to Case No. 14-1767GC. However, the Board denies jurisdiction over the inclusion of Part C Days in the Medicaid% and denies the transfer of this issue to Case No. 14-1766GC. Again, the Medicaid% was not adjusted in Richmond's RNPR. Similarly, the Board grants jurisdiction over the exclusion of DE Days from the SSI% and grants the transfer of this issue to Case No. 14-1769GC. The Board denies jurisdiction over the inclusion of DE Days in the Medicaid% and denies the transfer to Case No. 14-1768GC.

The Board also acknowledges the Provider's decision to withdrawal the ME Days issue from this case. This determination disposes all of the issues in Case No. 13-2247, and this case is now closed. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 1877.

Board Members Participating:

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

FOR THE BOARD:

Gregory H. Ziegler
Board Member

cc: Judith E. Cummings, Accounting Manager, CGS Administrators
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

MAY 17 2018

CERTIFIED MAIL

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

RE: Shasta Regional Medical Center, 05-0764, FYE 12/31/2011, Case No. 15-0379
HRS Prime Healthcare 2011 DSH SSI Percentage CIRP Group, Case No. 15-0001GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned individual appeal and the related group appeal. We note that Shasta Regional Medical Center appealed from a Notice of Program Reimbursement (NPR) for a 2011 cost reporting period. The 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). The pertinent facts with regard to these appeals and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

The sole remaining issue in the individual appeal is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. The Provider's issue description includes two components: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage (SSI Data Match) and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period (SSI Realignment).

There is a pending common issue related party (CIRP) group (case number 15-0001GC) for the SSI Data Match issue for FYE 2011, the Prime Healthcare 2011 DSH SSI Percentage CIRP Group. Upon review of the group, it is noted that Shasta Regional Medical Center, which is commonly controlled by Prime Healthcare, has not transferred or directly appealed the SSI Data Match portion of the issue into the group, case number 15-0001GC.

Board Determination:

Pursuant to 42 C.F.R. 405.1837(b)(1)

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the

aggregate, must bring the appeal as a group appeal.

Based on this regulation, it is mandatory that the first aspect of the SSI Provider Specific issue - the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, be pursued in the SSI Data Match case.[1] Therefore, the Board hereby transfers the SSI Data Match component of the issue for Shasta Regional Medical Center to the CIRP group, case number 15-0001GC.

The second aspect of the SSI Provider Specific issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, is hereby dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can appeal. As a result the Board finds that the appeal of this component of the issue is premature and dismisses it from case number 15-0379.

After the transfer of the SSI Data Match component and the dismissal of the SSI Realignment component of the SSI Provider Specific issue, there are no remaining issues in the individual appeal. Therefore case number 15-0379 is closed and removed 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.

Please advise the Board whether the CIRP group, case number 15-0001GC, can now be considered fully formed within 45 days of the date of this letter. If it is not yet complete, within the same time noted, identify the Providers for which you are still awaiting receipt of a final determination.

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

For the Board:

Gregory H. Ziegler
Board Member

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

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

[1] *See* Providers' Individual Appeal Request at Tab 3, Issue 1 and Appeal Request in 15-0001GC.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 17 2018

CERTIFIED MAIL

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

RE: HRS 2011 DSH SSI Percentage Group, CN 14-3237G

Specifically the following Providers with pending individual appeals:
Hardin Memorial Hospital, 18-0012, FYE 06/30/2011, CN 15-2440
East Valley Hospital Medical Center, 05-0205, FYE 12/31/2011, CN 15-2362
Lima Memorial Hospital, 36-0009, FYE 12/31/2011, CN 15-2068
Robinson Memorial Hospital, 36-0078, FYE 12/31/2011, CN 15-2364
University Medical Center of Southern Nevada, 29-0007, FYE 6/30/2011, CN 14-3244
North Oaks Hospital, 19-0015, FYE 12/31/2011, CN 15-2521
Yavapai Regional Medical Center –West, 03-0012, FYE 12/31/2011, CN 14-3603
Dallas Medical Center, 45-0379, FYE 12/31/2011, CN 14-4009

Dear Ms. Goron:

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

Pertinent Facts:

The sole issue remaining in the referenced cases is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. Each of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue directly into the optional group, case number 14-3237G.

The Providers are appealing two components of the SSI Percentage: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

With regard to the first aspect of the issue—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—the Board finds it is duplicative of the Systemic Errors issue that was directly added to case number 14-3237G and this aspect is hereby dismissed by the Board.[1]

[1] Providers' Individual Appeal Requests at Tab 3, Issue 1 and Appeal Request in 14-3237G.

With regard to the second aspect of the SSI Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—the Board finds it lacks jurisdiction and dismisses this aspect of the issue. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." The regulation permits one such request per year and the resulting percentage becomes the hospital's official Medicare/SSI percentage. In this case, the Providers have not made this request. Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can appeal. As a result the Board finds that the appeal of this issue is premature.

Since there are no other issues in these cases, the Board hereby closes case numbers **15-2440, 15-2362, 15-2068, 15-2364, 14-3244, 15-2521, 14-3603 and 14-4009** and removes them from the Board's docket.

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

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

FOR THE BOARD

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

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)
Lorraine Frewert, Noridian Healthcare Solutions (J-E)
Mounir Kamal, Novitas Solutions, Inc. (J-H)
John Bloom, Noridian Healthcare Solutions, LLC (J-F)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

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Dallas Medical Center, 45-0379, FYE 12/31/2011, CN 14-4009

Dear Ms. Goron:

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

Pertinent Facts:

The sole issue remaining in the referenced cases is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. Each of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue directly into the optional group, case number 14-3237G.

The Providers are appealing two components of the SSI Percentage: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

With regard to the first aspect of the issue—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—the Board finds it is duplicative of the Systemic Errors issue that was directly added to case number 14-3237G and this aspect is hereby dismissed by the Board.[1]

[1] Providers' Individual Appeal Requests at Tab 3, Issue 1 and Appeal Request in 14-3237G.

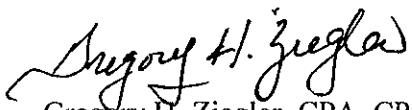
With regard to the second aspect of the SSI Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—the Board finds it lacks jurisdiction and dismisses this aspect of the issue. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." The regulation permits one such request per year and the resulting percentage becomes the hospital's official Medicare/SSI percentage. In this case, the Providers have not made this request. Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can appeal. As a result the Board finds that the appeal of this issue is premature.

Since there are no other issues in these cases, the Board hereby closes case numbers **15-2440, 15-2362, 15-2068, 15-2364, 14-3244, 15-2521, 14-3603 and 14-4009** and removes them from the Board's docket.

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

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

FOR THE BOARD



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

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)
Lorraine Frewert, Noridian Healthcare Solutions (J-E)
Mounir Kamal, Novitas Solutions, Inc. (J-H)
John Bloom, Noridian Healthcare Solutions, LLC (J-F)
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

MAY 18 2018

CERTIFIED MAIL

Mridula Bhatnagar
Director - Client Services
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520 2546

RE: Dignity Health 2012 Accuracy of CMS Developed SSI Ratio CIRP Group
Case No. 15-0881GC
Specifically: St. Bernardine Medical Center, Provider No. 05-0129, FYE 06/30/2012,
Case No. 15-2340

Dear Ms. Bhatnagar:

The Provider listed above appealed from a Notice of Program Reimbursement (NPR) for a 2012 cost reporting period. The 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) and was issued in October 2014.

The only remaining issue in the individual appeal is the *Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Ratio Realignment (SSI Realignment)*. The Provider transferred the *Accuracy of CMS Developed SSI Ratio (SSI Accuracy)* issue to case number 15-0881GC, the Dignity Health 2012 Accuracy of CMS Developed SSI Ratio CIRP Group.

Board's Decision

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

The Board finds that it does not have jurisdiction over the SSI Realignment issue for St. Bernardine Medical Center. The jurisdictional analysis for the SSI Realignment 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 SSI Accuracy issue that was transferred to case number 15-0881GC and is hereby dismissed by the Board.[1]

The DSH Payment/SSI Ratio Alignment to Provider's Cost Reporting Year (SSI Realignment) issue concerns "the SSI percentage utilized in the development of the DSH payment is incorrectly stated because the SSI percentage does not align to the Provider's cost reporting year."[2]

The Providers' Accuracy of SSI Ratio issue as stated in the group appeal request for case number 15-0881GC is "Whether the SSI Ratio developed by CMS is calculated accurately?" Specifically, the Providers dispute

> . . . the SSI percentage developed by CMS and utilized by the Medicare Administrative Contractor (MAC) in their updated calculation of the Medicare Inpatient Prospective Payment System's DSH payment. [Dignity Health] contends CMS failed to disclose the underlying patient data of their calculation proving the SSI ratio issued is calculated in the manner prescribed by CMS Ruling 1498-R.

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 SSI Realignment issue statement is duplicative of the SSI Accuracy issue that has been transferred to the 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 St. Bernardine Medical Center transferred the SSI Accuracy issue to a group appeal, the Board hereby dismisses the first portion of the SSI Realignment issue because it is duplicative of the SSI Accuracy issue.

The second aspect of the SSI Realignment 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 . . . ". The Provider indicates it ". . . will consider requesting CMS realign the Provider's SSI Percentage to the Provider's cost reporting year."[3] As a request has not yet been made, there is no final determination from which the Provider can appeal this issue. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's issue statement.

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

Conclusion

The only remaining issue in this appeal is the SSI Realignment issue and the Board finds that it does not have jurisdiction over this issue for St. Bernardine Medical Center. The Board finds that the Provider's challenge to the DSH SSI regulation and statute is properly pending in a CIRP group. With respect to the request for a 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 number 15-2340 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:
Gregory H. Ziegler, CPA, CPC-A
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.

FOR THE BOARD

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

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

MAY 1 8 2018

CERTIFIED MAIL

Mridula Bhatnagar
Director - Client Services
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520 2546

RE: Dignity Health 2014 Accuracy of CMS Developed SSI Ratio CIRP Group
Case No. 16-2565GC
Specifically: St. Rose Dominican Hospital - Siena, Provider No. 29-0045, 06/30/2014, Case No. 17-1501

Dear Ms. Bhatnagar:

The Provider listed above appealed from a Notice of Program Reimbursement (NPR) for a 2014 cost reporting period. The 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) and was issued in November 2016.

The only remaining issue in the individual appeal is the *Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Ratio Realignment (SSI Realignment)*. The Provider transferred the *Accuracy of CMS Developed SSI Ratio (SSI Accuracy)* issue to case number 16-2565GC, the Dignity Health 2014 Accuracy of CMS Developed SSI Ratio CIRP Group.

Board's Decision

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

The Board finds that it does not have jurisdiction over the SSI Realignment issue for St. Rose Dominican Hospital - Siena. The jurisdictional analysis for the SSI Realignment 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 SSI Accuracy issue that was transferred to case number 16-2565GC and is hereby dismissed by the Board.[1]

The DSH Payment/SSI Ratio Alignment to Provider's Cost Reporting Year (SSI Realignment) issue concerns "the SSI percentage utilized in the development of the DSH payment is incorrectly stated because the SSI percentage does not align to the Provider's cost reporting year."[2]

The Providers' Accuracy of SSI Ratio issue as stated in the group appeal request for case number 16-2565GC is "Whether the SSI Ratio developed by CMS issued on October 17, 2012 is calculated accurately?" Specifically, the Providers dispute

> . . . the SSI percentage developed by CMS and utilized by the Medicare Administrative Contractor (MAC) in their updated calculation of the Medicare Inpatient Prospective Payment System's DSH payment. [Dignity Health] contends CMS failed to disclose the underlying patient data of their calculation proving the SSI ratio issued is calculated in the manner prescribed by CMS Ruling 1498-R.

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 SSI Realignment issue statement is duplicative of the SSI Accuracy issue that has been transferred to the 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 St. Rose Dominican Hospital - Siena transferred the SSI Accuracy issue to a group appeal, the Board hereby dismisses the first portion of the SSI Realignment issue because it is duplicative of the SSI Accuracy issue.

The second aspect of the SSI Realignment 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 . . . ". The Provider indicates it ". . . will consider requesting CMS realign the Provider's SSI Percentage to the Provider's cost reporting year."[3] As a request has not yet been made, there is no final determination from which the Provider can appeal this issue. Based on this reasoning, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's issue statement.

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

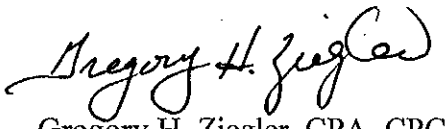
Conclusion

The only remaining issue in this appeal is the SSI Realignment issue and the Board finds that it does not have jurisdiction over this issue for St. Rose Dominican Hospital - Siena . The Board finds that the Provider's challenge to the DSH SSI regulation and statute is properly pending in a CIRP group. With respect to the request for a 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 number 17-1501 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:
Gregory H. Ziegler, CPA, CPC-A
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.

FOR THE BOARD



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

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

cc: John Bloom, Noridian Healthcare Solutions, LLC (J-F)
Lorraine Frewert, Noridian Healthcare Solutions (J-E)
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

Certified Mail

MAY 21 2018

Baptist Health System
Shaw Seely
Director of Reimbursement
800 Prudential Drive
Jacksonville, FL 32207

Re: Baptist Medical Center, Provider No. 10-0088, FYE 09/30/14, Case No. 18-1124

Dear Mr. Shaw Seely:

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

Background

On March 26, 2018, the Board received the provider's individual appeal based on a Notice of Program Reimbursement ("NPR"). On March 28, 2018, the Board issued an Acknowledgement and Critical Due Dates notice in accordance with Board Rule 9.[1]

Decision of the Board

The Board finds that the Provider's appeal request is jurisdictionally deficient as the Provider failed to submit the final determination under appeal.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835, a provider has a right to a hearing on a final contractor or Secretary determination for the provider's cost reporting period if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for a hearing is no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

Pursuant to 42 C.F.R. § 405.1835(b), if a Provider's appeal request does not meet the requirements of paragraphs (b)(1) through (b)(3) of the same section, the Board may dismiss with prejudice the appeal, or take any other remedial action it considers appropriate. Paragraphs (b)(1) through (b)(3) state in part that the following must be included in the Provider's request:

[1] Board Rule 9 states in part, "The Board will send an acknowledgement via e-mail indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient."

(1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of the same section, including a specific identification of the final contractor or Secretary determination under appeal.

(2) A separate explanation for each specific item under appeal and a description of how the provider is dissatisfied with the specific aspects of the final determination.

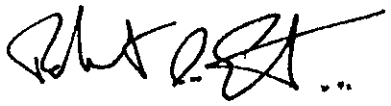
(3) A copy of the determination, including any other documentary evidence the provider considers necessary to satisfy the hearing request requirements.

Because the Provider failed to submit the final determination under appeal, the Provider did not meet the regulatory requirements for filing an appeal before the Board. The Provider failed to document that it has a final determination from which an appeal may be filed. Therefore, the Board finds that dismissal is appropriate and closes Case No. 18-1124.

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

FOR THE BOARD:



Board Member

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 22 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**

18-0108G	K&S 2006 DSH SSI Fraction Medicare Advantage Days Group
18-1121G	K&S 2009 DSH Medicare Advantage Days Group II
18-1123G	K&S 2010 DSH Medicare Advantage Days Group II
18-1131G	K&S 2006 DSH Medicaid Fraction Medicare Advantage Days Group

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 4, 2018 requests for expedited judicial review (EJR) (received May 7, 2018) for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> [W]hether CMS unlawfully treats days for which Medicare Part A did not make payment, namely Medicare Advantage days which are paid under Medicare Part C, as days for which patients are entitled to benefits under Medicare Part A for purposes of calculating the Medicare disproportionate share ("DSH") payment.[1]

Statutory and Regulatory Background: Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[2] Under PPS,

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

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

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

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

Providers' Request for EJR

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

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

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[22] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part 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

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

lacks the authority to grant. The Providers maintain that, since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006, 2009 and 2010.

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

On August 21, 2008, new regulations governing the Board were effective.[25] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[26] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[27]

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[23] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[24] *Bethesda at 1258-59.*
[25] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[26] 201 F. Supp. 3d 131 (D.D.C. 2016)
[27] *Banner* at 142.

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[28] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or self-disallowed the issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[29] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request span fiscal years 2006, 2009 and 2010, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed,* No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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[28] See 42 C.F.R. § 405.1889(b)(1) (2008).
[29] *See* 42 C.F.R. § 405.1837.

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

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:

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

FOR THE BOARD:

Gregory H. Ziegler
Board Member

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

cc: Cecile Huggins, Palmetto GBA (Certified Mail w/Schedules of Providers)
Geoff Pike, First Coast Service Options (Certified Mail w/Schedules of Providers)
Wilson Leong, Esq., Federal Specialized Services (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

MAY 23 2018

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

RE: HRS Prime Healthcare 2009 DSH SSI Percentage (Systemic Errors) Group, CN 14-1521GC
Specifically the following Providers with pending individual appeals:
Paradise Valley Hospital, Provider No. 05-0024, FYE 12/31/2009, CN 16-1359
Centinela Hospital Medical Center, Provider No. 05-0739, FYE 12/31/2009, CN 18-0543
Shasta Regional Medical Center, Provider No. 05-0764, FYE 12/31/2009, CN 15-1071

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned group and the related individual appeals. We note that each of the Providers listed above appealed from a Notice of Program Reimbursement (NPR) for a 2009 cost reporting period.[1] The NPRs were issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). The pertinent facts with regard these cases and the Board's determination are set forth below:

I. Case Numbers 16-1359 and 15-1071

SSI Provider Specific Issue

The sole issue remaining in case numbers 16-1359 and 15-1071 is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. Each of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue directly into the CIRP group, case number 14-1521GC.

The Providers are appealing two components of the SSI Percentage: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

With regard to the first aspect of the issue—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—the Board finds it is duplicative of the Systemic Errors issue that was directly added to 14-1521GC and this aspect is hereby dismissed by the Board.[2]

With regard to the second aspect of the SSI Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—

[1] Centinela Hospital Medical Center appealed from a Revised NPR.
[2] Providers' Individual Appeal Requests at Tab 3, Issue 1 and Appeal Request in 14-1521GC.

the Board finds it lacks jurisdiction and dismisses this aspect of the issue. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." The regulation permits one such request per year and the resulting percentage becomes the hospital's official Medicare/SSI percentage. In this case, the Providers have not made this request. Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can appeal. As a result the Board finds that the appeal of this issue is premature.

Since there are no other issues in these cases, the Board hereby closes case numbers 15-1071 and 16-1359 and removes them from the Board's docket.

II. Case Number 18-0543

Centinela Hospital Medical Center is also part of the Prime Healthcare chain. HRS filed an individual appeal request for the Provider based on the RNPR issued July 27, 2017. The appeal included only two issues: SSI (Provider Specific) and Medicaid Eligible Days.

SSI Provider Specific Issue

As noted in case numbers 16-1359 and 15-1071, the Provider in case number 18-0543 is also appealing two components of the SSI Percentage: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. However, Centinela Hospital Medical Center has not directly added or transferred the SSI issue to the CIRP group, case number 14-1521GC.

Pursuant to 42 C.F.R. 405.1837(b)(1)

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.

Based on this regulation, it is mandatory that the first aspect of the SSI Provider Specific issue - the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, be pursued in the SSI Systemic Errors group case.[3] Therefore, the Board hereby transfers the SSI Systemic Errors component of the issue for Shasta Regional Medical Center to the CIRP group, case number 14-1521GC.

The second aspect of the SSI Provider Specific issue - the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period, is hereby dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for

[3] *See* Providers' Individual Appeal Request at Tab 3, Issue 1 and Appeal Request in 14-1521GC.

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 (Medicare Contractor), a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can appeal. As a result the Board finds that the appeal of this component of the issue is premature and dismisses it from case number 18-0543.

Medicaid Eligible Days

Centinela Hospital Medical Center contends that the Medicare Contractor ". . . failed to include all Medicaid eligible days, including . . . Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date, restricted aid days, and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation."[4] The Provider referenced audit adjustment 5 (and S/D) for the Medicaid Eligible Days issue.

Audit adjustment 5 on the RNPR relates to "Allowable DSH % Review of Sample Documentation" on Worksheet E, Part A. Since the Medicaid Eligible Days issue was not adjusted in the RNPR, the Board does not have jurisdiction over this Provider's appeal pursuant to 42 C.F.R. § 405.1889. This regulation states that any matter not specifically revised may not be considered in any appeal of the revised determination.

Therefore, the Board finds it lacks jurisdiction and dismisses the Medicaid Eligible Days issue from case number 18-0543. Since there are no other issues in this appeal, the case is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD

Gregory H. Ziegler

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

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

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

[4] *See* Provider's individual appeal request at Tab 3, Issue 2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671
MAY 24 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**

13-1146GC	Ardent Health Services 2008 Part C Days DSH Patient Percentage CIRP Group
13-1350GC	Ardent Health Services 2007 Part C Days DSH Patient Percentage CIRP Group
14-0371GC	Ardent Health Services 2009 DSH SSI Fraction Medicare Advantage Days CIRP
14-2717GC	Ardent Health Services 2009 DSH Medicaid Fraction Medicare Advantage Days CIRP
14-2875GC	Ardent Health Services 2010 DSH SSI Fraction Part C Days CIRP Group
14-2878GC	Ardent Health Services 2010 DSH Medicaid Ratio Part C Days CIRP Group

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 10, 2018 requests for expedited judicial review (EJR) (received May 11, 2018) for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> [W]hether CMS unlawfully treats days for which Medicare Part A did not make payment, namely Medicare Advantage days which are paid under Medicare Part C, as days for which patients are entitled to benefits under Medicare Part A for purposes of calculating the Medicare disproportionate share ("DSH") payment.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] Providers' EJR Request at 1.

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

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

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

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

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

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

> 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

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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).

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

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

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

Providers' Request for EJR

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

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

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[22] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part 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

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

lacks the authority to grant. The Providers maintain that, since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdictional Determination

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

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

On August 21, 2008, new regulations governing the Board were effective.[25] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[26] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[27]

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[23] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[24] *Bethesda at 1258-59.*
[25] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[26] 201 F. Supp. 3d 131 (D.D.C. 2016)
[27] *Banner* at 142.

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[28] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or self-disallowed the issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[29] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request span fiscal years 2007, 2008, 2009 and 2010, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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[28] See 42 C.F.R. § 405.1889(b)(1) (2008).
[29] *See* 42 C.F.R. § 405.1837.

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

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:

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

FOR THE BOARD:

Gregory H. Ziegler
Board Member

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 2 4 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**

14-0498GC	Saint Francis Hospital 2009 DSH SSI Fraction Part C Days CIRP Group
14-0499GC	Saint Francis Hospital 2009 DSH Medicaid Fraction Part C Days CIRP Group
18-0507GC	Saint Francis Health System 2010 SSI Fraction Part C Days CIRP Group
18-0509GC	Saint Francis Health System 2010 Medicaid Fraction Part C Days CIRP Group
18-1283GC	Saint Francis Health System 2011 DSH Part C Days CIRP Group
18-1307GC	Saint Francis Health System 2012 DSH Part C Days CIRP Group

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 18, 2018 requests for expedited judicial review (EJR) (received May 21, 2018) for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> [W]hether CMS unlawfully treats days for which Medicare Part A did not make payment, namely Medicare Advantage days which are paid under Medicare Part C, as days for which patients are entitled to benefits under Medicare Part A for purposes of calculating the Medicare disproportionate share ("DSH") payment.[1]

Statutory and Regulatory Background: Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[2] Under PPS,

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

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

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

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

Providers' Request for EJR

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

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

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[22] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part 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

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

lacks the authority to grant. The Providers maintain that, since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2009 through 2012.

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

On August 21, 2008, new regulations governing the Board were effective.[25] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[26] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[27]

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[23] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[24] *Bethesda at 1258-59.*
[25] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[26] 201 F. Supp. 3d 131 (D.D.C. 2016)
[27] *Banner* at 142.

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[28] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or self-disallowed the issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[29] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

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

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[28] See 42 C.F.R. § 405.1889(b)(1) (2008).
[29] *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:

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

FOR THE BOARD:

Gregory H Ziegler
Board Member

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 24 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**

13-3817GC	YNHHS 2008 DSH Medicare/Medicaid Part C Days Group
13-3959GC	YNHHS 2006-2007 DSH Medicare/Medicaid Part C Days Group
14-0476GC	YNHHS 2009 DSH Medicare/Medicaid Part C Days Group
14-1438GC	YNHHS 2010 DSH Medicare/Medicaid Part C Days Group
15-0683GC	YNHHS 2011 DSH Medicare/Medicaid Part C Days Group
15-2525GC	YNHHS 2012 DSH Medicare/Medicaid Part C Days Group
16-1977GC	YNHHS 2013 DSH Medicare/Medicaid Part C Days Group

Dear Mr. Rosenberg:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 16, 2018 requests for expedited judicial review (EJR) (received May 17, 2018) for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> [W]hether Medicare Part C enrollees (i.e., those beneficiaries who elected to be covered by Medicare Advantage/Part C plan[s]) are entitled to benefits under Part A and should be included in the numerator and denominator of the Medicare/SSI fraction of the DSH [disproportionate share hospital] calculation or, if not, whether those days should be included within the numerator of the Medicaid fraction of the DSH calculation when the beneficiary also is eligible for Medicaid coverage.[1]

[1] Providers' EJR Request at 2.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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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.

> *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

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

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

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

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006-2013.

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

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

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

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

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

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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[26] *See* 42 C.F.R. § 405.1837.

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

Gregory H Ziegler
Board Member

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

cc: Pam VanArsdale, NGS (Certified Mail w/Schedules of Providers)
Wilson Leong, Esq., Federal Specialized Services (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 2 4 2018

CERTIFIED MAIL

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

RE: Carolinas Hospital System, Provider No. 42-0091
FYE 6/30/1997 Case No. 16-2395
FYE 6/30/1998 Case No. 16-2394

Dear Mr. Summar:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeals. The pertinent facts in both cases and the jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On September 9, 2016, the Provider filed appeals from the revised NPRs, both dated March 9, 2016, that were issued as a result of administrative resolutions in case numbers 08-1665 (FY 1997) and 08-1616 (FY 1998).[1] The only issue in each appeal is Medicaid Eligible Days.

By email dated January 2, 2018, Board staff requested that the Provider provide additional information to support the adjustments made in the revised NPRs. The Provider was to respond in 10 days. To date, there has been no response.

The Medicare Contractor filed a jurisdictional challenge in both cases on April 30, 2018.

Medicare Contractor's Contentions:

The Medicare Contractor contends that the Board does not have jurisdiction over the appeals as:

- The days in dispute were not adjusted in the revised NPRs.
- The adjustments cited by the Provider (Adjustment #1 in both appeals) was proposed to properly report the DSH payment in accordance with the administrative resolutions and the Provider's simultaneous reopening requests for each year. The days in dispute are additional days submitted during the appeals of the prior cases (08-1665 and 08-1616) and are not related to Adjustment #1.

The Medicare Contractor cites 42 C.F.R. § 405.1889:

> (1) Only those matters that are specifically revised in the revised determination or decision are within the scope of any appeal of the revised determination or decision.

[1] Case Nos. 08-1665 and 08-1616 were closed on 9/22/2015.

> (2) Any matter that is not specifically revised (including any matter that was reopened and not revised) may not be considered in any appeal of the revised determination or decision.

The Medicare Contractor concludes that the matters appealed were not matters revised on the reopening and, therefore, are outside the Board's authority for review.

Provider's Contentions:

The Provider did not file a brief in response to the Medicare Contractor's jurisdictional challenge.

Board Determination:

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

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

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

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

Medicaid Eligible Days Issue

The Board finds that it does not have jurisdiction over the Medicaid Eligible Days issue for this Provider for FYEs 1997 and 1998. The revised NPRs for these cases were issued as the result of Administrative Resolutions (ARs) in case numbers 08-1665 and 08-1616. The Provider did not

supply the requested workpapers for the ARs so there is no evidence to support an adjustment to Medicaid Eligible Days for either year. Further, based on the reasoning put forth in *Illinois Masonic Medical Center v. BCBSA*,[2] the Board finds that it does not have jurisdiction over the additional Medicaid eligible days the Provider is requesting.

In *Illinois Masonic*, the provider appealed Medicaid eligible days and transferred the issue to a group appeal. Ultimately, that group appeal resulted in an Administrative Resolution in which the provider and the intermediary [Medicare Contractor] jointly agreed that the provider's representative (QRS) was to submit documentation to support the assertion that the days claimed are not exempt unit days. QRS submitted this documentation; the intermediary reviewed it and subsequently issued a revised NPR on December 3, 2007. The provider had claimed an additional 230 Medicaid eligible days, of which the Intermediary made an adjustment to add 24 of those, which was reflected in the revised NPR. On May 28, 2008, the provider submitted a timely request for hearing based on the revised NPR, and requested the inclusion of 1,175 additional Medicaid eligible days. On November 25, 2009, the provider identified a total of 2,244 additional unpaid, but Medicaid eligible days in dispute, including the 1,175 days noted in the appeal request. The Board determined that it lacked jurisdiction under 42 U.S.C. § 1395oo(a) because the provider could not be "dissatisfied" with the intermediary's final determination in the revised NPR. The provider conceded that there was no overlap between the 230 days the provider originally requested, and the 2,244 days it requested in its appeal from the revised NPR. The Board, therefore, concluded that the intermediary could not have reviewed those 2,244 days when it revised the cost report and, consequently, the provider could not have been dissatisfied with the final determination because the days were not part of the Intermediary's determination.

The Board's reasoning in *Illinois Masonic* is applicable to Carolinas Health System's appeals of the Medicaid eligible days. The revised NPRs in these cases reflect additional days resulting from an administrative resolution providing a specific number of additional eligible days. In both appeals, the Provider is requesting an additional 150 days. Like in *Illinois Masonic,* the Provider has not documented that the Medicare Contractor considered those additional days when it reopened the Provider's cost reports. Therefore, the Provider cannot meet the dissatisfaction requirement for Board jurisdiction.

According to the Medicare Contractor, the days in dispute in both appeals are in addition to the days included in the implementation of the administrative resolution of Case Nos. 08-1665 and 08-1616 and were not actually adjusted in the revised NPRs under appeal.

Conclusion:

The Board finds that it does not have jurisdiction over the Medicaid Eligible Days issue appealed in case numbers 16-2394 and 16-2395. The Board hereby dismisses the issue and closes case numbers 16-2394 and 16-2395.

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[2] PRRB Dec. 2010-D47.

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

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

FOR THE BOARD

Board Member

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

cc: Laurie Polson, Palmetto GBA c/o National Government Services
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

MAY 2 5 2018

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

RE: HRS Prime Healthcare 2014 DSH SSI Percentage CIRP Group, CN 16-1698GC
Specifically: Providence Medical Center, Provider No. 17-0146, FYE 12/31/2014, CN 17-1968
Shasta Regional Medical Center, Provider No. 05-0764, FYE 12/31/2014, CN 17-1467
West Anaheim Medical Center, Provider No. 05-0426, FYE 12/31/2014, CN 17-1490
Lower Bucks Hospital, Provider No. 39-0070, FYE 12/31/2014, CN 17-1656
Saint John Hospital, Provider No. 17-0009, FYE 12/31/2014, CN 17-1952

Dear Ms. Goron:

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

Pertinent Facts:

All of the providers listed above appealed from Notices of Program Reimbursement (NPR) for a 2014 cost reporting period. The NPRs include the most recent SSI % re-calculated by CMS (Post 2011 Final Rule with new data matching).

The last issue in these individual cases (with the exception of case number 17-1952) is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. All of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage* issue by directly adding it into case number 16-1698GC.

In case number 17-1952, Saint John Hospital also appealed the Two Midnight Census IPPS Payment Reduction issue.

Board Determination:

1. **SSI Provider Specific Issue**

The sole issue remaining in case numbers 17-1968, 17-1467, 17-1490 and 17-1656 is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. Each of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue by directly adding the issue into the HRS Prime Healthcare 2014 DSH SSI Percentage CIRP Group, case

number 16-1698GC.

The Providers are appealing two components of the SSI Percentage: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

With regard to the first aspect of the issue—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—the Board finds it is duplicative of the Systemic Errors issue that was directly added/transferred to 16-1698GC and this aspect is hereby dismissed by the Board.[1]

With regard to the second aspect of the SSI Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—the Board finds it lacks jurisdiction and dismisses this aspect of the issue. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." The regulation permits one such request per year and the resulting percentage becomes the hospital's official Medicare/SSI percentage. In these cases, the Providers have not made this request. Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can appeal. As a result the Board finds that the appeal of this issue is premature.

Since there are no other issues in these cases, the Board hereby closes case numbers 17-1968, 17-1467, 17-1490 and 17-1656 and removes them from the Board's docket.

2. **Two Midnight Census IPPS Payment Reduction Issue**

Saint John Hospital also appealed the Two Midnight Census IPPS Payment Reduction issue in its individual appeal.

Pursuant to 42 C.F.R. 405.1837(b)(1)

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.

Based on this regulation, it is mandatory that Two Midnight issue be pursued in the HRS Prime Healthcare 2014 Two Midnight CIRP Group. Therefore, the Board hereby transfers the Two Midnight issue for Saint John Hospital from case number 17-1952 to the CIRP group, case number 16-1795GC.

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[1] Providers' Individual Appeal Requests at Tab 3 and Appeal Request in 16-1698GC.

Since there are no remaining issues in case number 17-1952, the Board hereby closes the case and removes it from the Board's docket.

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

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

FOR THE BOARD

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

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

cc: Lorraine Frewert, Noridian Healthcare Solutions (J-E)
Byron Lamprecht, Wisconsin Physicians Service (J-5)
Bruce Snyder, Novitas Solutions, Inc. (J-L)
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

MAY 25 2018

CERTIFIED MAIL

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

RE: HRS LSU 2009 DSH SSI Percentage (Systemic Errors) CIRP Group, CN 14-1280GC
Specifically:
Leonard J. Chabert Medical Center, Provider No. 19-0183, FYE 06/30/2009, CN 14-1249
W.O. Moss Regional Medical Center, Provider No. 19-0161, FYE 06/30/2009, CN 16-2164

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned group and the related individual appeals. We note that each of the Providers listed above appealed from a Notice of Program Reimbursement (NPR) for a 2009 cost reporting period. The NPRs were issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). The pertinent facts with regard these cases and the Board's determination are set forth below:

Pertinent Facts:

Both of the provider's listed above appealed from a Notice of Program Reimbursement (NPR) for a 2009 cost reporting period. Each of the NPRs include the most recent SSI % re-calculated by CMS (Post 2011 Final Rule with new data matching).

The last issue in both of these individual cases is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. Both Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage* issue (by transferring or directly adding it) into case number 14-1280GC (See group appeal file attached).

Board Determination:

The sole issue remaining in case numbers 14-1249 and 16-2164 is the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue. Each of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)* issue (by directly adding or transferring the issue) into the CIRP group, case number 14-1280GC.

The Providers are appealing two components of the SSI Percentage: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

With regard to the first aspect of the issue—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—the Board finds it is duplicative of the Systemic Errors issue that was directly added/transferred to 14-1280GC and this aspect is hereby dismissed by the Board.[1]

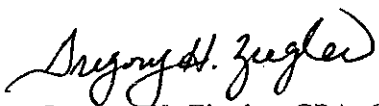
With regard to the second aspect of the SSI Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—the Board finds it lacks jurisdiction and dismisses this aspect of the issue. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." The regulation permits one such request per year and the resulting percentage becomes the hospital's official Medicare/SSI percentage. In these cases, the Providers have not made this request. Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can appeal. As a result the Board finds that the appeal of this issue is premature.

Since there are no other issues in these cases, the Board hereby closes case numbers **14-1249 and 16-2164** and removes them from the Board's docket.

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

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

FOR THE BOARD



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

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

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

[1] Providers' Individual Appeal Requests at Tab 3 and Appeal Request in 14-1280GC.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 2 5 2018

Certified Mail

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

RE: **Expedited Judicial Review Determination**

15-2047GC Baptist Health 2005 Medicaid Fraction Part C Days

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' May 14, 2018 request for expedited judicial review (EJR) (received May 16, 2018). The decision of the Board with respect to the request for EJR for the above identified case is set forth below.

Issue for Which EJR was Requested

The Providers requested EJR for the following issue:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

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

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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).

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> *proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

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

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

Providers' Position

The Providers point out that the Board is bound by the 2004 Rule found in codified at 42 C.F.R. §§ 405.106(b)(2)(I)(B) and (b)(2)(iii)(B) and the Secretary has not acquiesced to the decision in *Allina Health Services v. Sebelius*. In Allina, the Circuit Court for the District of Columbia issued a vacatur of the 2004 Rule that included Part C Days in the Medicare Fraction of the DSH adjustment and excluded the days from the Medicaid fraction. The Providers contend that the pre-2004 version of the DSH regulation should remain in place, providing that the numerator of the DSH fraction include only "covered patient days that . . . are furnished to patients who, during that month were entitled to both Medicare Part A and SSI."[21]

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

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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] 42 C.F.R. § 412.106(b)(2)(i)(2003).

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 2005.

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] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[23]

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

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request involves the fiscal year 2005, thus the appealed cost reporting 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

[22] 108 S.Ct. 1255 (1988).
[23] *Bethesda at 1258-59.*
[24] *See* 42 C.F.R. § 405.1837.

acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed,* No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

Gregory H. Ziegler
Board Member

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

cc: Geoff Pike, First Coast Service Options (Certified Mail w/Schedule of Providers)
Wilson Leong, (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 3 0 2018

CERTIFIED MAIL

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

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

RE: Jurisdictional Challenge
Provider: Yale New Haven Hospital
Provider No.: 07-0022
FYE: 2014
Case No.: 14-2087

Dear Mr. Roth and Ms. VanArsdale,

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

Pertinent Facts:

The Provider timely filed its appeal request with the Provider Reimbursement Review Board ("Board") from the August 19, 2013 Final Rule setting forth the 2014 IPPS rates.[1] The Provider appealed one issue, which is the only issue that is currently in the appeal: Uncompensated Care DSH Calculation for Merged Providers from FY 2014 IPPS.

Federal Specialized Services ("FSS"), on behalf of the Medicare Contractor, has filed a Jurisdictional Challenge over the Provider's appeal arguing that it is not an appealable issue. The Provider filed two jurisdictional responses to the jurisdictional challenge, the second of which addressed a relevant decision issued by the D.C. District Court.

Medicare Contractor's Arguments:

The Medicare Contractor contends that the Board does not have jurisdiction over the Uncompensated Care DSH issue. According to the Medicare Contractor, the Provider has challenged the validity of the Secretary's determination of its DSH payments for uncompensated care costs for fiscal year 2014 as it relates to Factor 3. The Medicare Contractor concludes that Congress, in enacting 42 U.S.C. § 1395ww(r)(3), explicitly barred administrative and judicial review of the new DSH methodology, therefore the Board does not have jurisdiction over the Uncompensated Care DSH issue.

[1] 78 Fed. Reg. 50496 (Aug. 19, 2013).

Provider's Jurisdictional Response:

In its Supplemental Jurisdictional Response, the Provider attempts to establish that the holdings by both the D.C. District Court and the D.C. Circuit Court in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[2]("*Tampa General*") do not apply to the Provider's current appeal before the Board because it was an *ultra vires* error by CMS, the review of which cannot be limited.[3] The Provider also attempts to distinguish the *Tampa General* District Court decision from this appeal, by arguing that the Provider is not challenging CMS' use of March 2013 as the time period for the source of data to calculate UC DSH payments, but rather the challenge is to CMS' "unexplained failure" to include all of the hospital's data.[4] The Provider also points to the fact that CMS reversed its error for FY 2015.[5] Finally, the Provider argues that a decision in its favor will have extremely limited effect because CMS' exclusion of subsumed areas of subsection (d) hospitals from the uncompensated care DSH calculation only applies for federal fiscal year 2014.[6]

Board's Decision:

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

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[7]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[8] upheld the D.C. District Court's decision[9] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

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

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[2] 89 F. Supp. 3d. 121 (D.D.C. 2015); 830 F.3d 515 (D.C. Cir. 2016).
[3] Provider's Supplemental Jurisdiction Response at 1.
[4] *Id.* at 2.
[5] *Id.* at 5.
[6] *Id.* at 10.
[7] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[8] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[9] 89 F. Supp. 3d 121 (D.D.C. 2015).

data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[10] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[11]

The Board finds that the same findings are applicable to Yale New Haven Hospital's challenge to its 2014 uncompensated care payment. The Provider attempts to distinguish its appeal from the facts in *Tampa General*, it does not do so successfully.

Although the Provider here is challenging a different part of the uncompensated care calculation than in *Tampa General*, it is still challenging the underlying data. The Secretary uses historical data as part of its calculation. The Provider explains that in some instances, during periods after the historical data period, providers merged while remaining eligible to receive UC payments. In instances where a merger occurred after the periods from which the calculation data was extracted, CMS chose not to combine the data of the two providers that merged, even when both were otherwise DSH eligible. Instead, CMS chose only to use the historical data for the surviving merged Provider.[12]

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH issue in this appeal because judicial and administrative review of the calculation is barred by statute and regulation.

As the UC DSH issue is the only issue in the appeal, case number 14-2087 is hereby closed and removed from the Board's docket.

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

FOR THE BOARD

Charlotte F. Benson

Charlotte F. Benson, CPA
Board Member

cc: Edward Lau, Esq., FSS

[10] 830 F.3d 515, 517.
[11] *Id.* at 519.
[12] Provider's Appeal Request (citing to 78 Fed. Reg. 50496, 50642 (Aug. 19, 2013)).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAY 30 2018

CERTIFIED MAIL

Amy J. Stephens, Director
WVU Medicine
Corporate Finance & Reimbursement
3040 University Avenue
Morgantown, WV 26505

Nancy Repine, Assistant Vice President
WVU Medicine
Finance & Reimbursement
3040 University Avenue
Morgantown, WV 26505

RE: QRS WVUHS 2012 DSH SSI Percentage (Systemic Errors) CIRP Group
Case No. 16-1686GC
Specifically: United Hospital, 51-0006, 12/31/2012, Case No.16-1028
West Virginia University Hospital, 51-0001, 12/31/2012, Case No.16-0005
City Hospital, 51-0008, 12/31/2012, Case No.16-0578

Dear Ms. Stephens and Ms. Repine:

The Providers listed above appealed from Notices of Program Reimbursement (NPRs) for a 2012 cost reporting period. The NPRs were issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching).

The only remaining issue in the individual appeals is the *Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Ratio Realignment (SSI Realignment)*. WVU Medicine authorized QRS to transfer the *Accuracy of CMS Developed SSI Ratio (SSI Accuracy)* issues to case number 16-1686GC, the QRS WVUHS 2012 DSH SSI Percentage (Systemic Errors) CIRP Group.

Board's Decision

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

The Board finds that it does not have jurisdiction over the SSI Realignment issue for United Hospital, West Virginia University Hospital and City Hospital. The jurisdictional analysis for the SSI Realignment 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 SSI Accuracy issue that was transferred to case number 16-1686GC and is hereby dismissed by the Board.[1]

The DSH Payment/SSI Percentage (Provider Specific) issue concerns "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 Providers' SSI Percentage issue as stated in the group appeal request for case number 16-1686GC is "Whether the Secretary properly calculated the Providers' Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") Percentage. Specifically, the Providers dispute

> . . . the SSI percentage calculated by CMS and used by the Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F, Supp. 2d 37, 44 (D.D.C. 2008) 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 SSI Provider Specific issue statement is duplicative of the SSI Systemic issue that has been transferred to the 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 referenced Providers transferred the SSI (Systemic Errors) issue to a group appeal, the Board hereby dismisses the first portion of the SSI Provider Specific issue as it is duplicative of the issue already being handled in the group.

The second aspect of the SSI (Provider Specific) issue – the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period – is hereby dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ". The issue statement indicates that each Provider ". . . preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[3] As the Providers have not yet requested a realignment, there are no final determinations from which the Providers can appeal this issue. Based on this reasoning, the

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[1] *See* Providers' Individual Appeal Requests at Tab 3.
[2] *See* Group Appeal Request at Tab 2.
[3] *See* Providers' Individual Appeal Requests at Tab 3

Board finds that it does not have jurisdiction over the Provider Specific portion of the SSI Percentage issue.

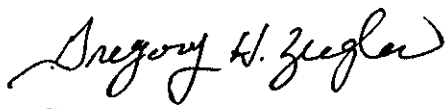
Conclusion

The only remaining issue in the referenced individual appeals is the SSI Provider Specific issue and the Board finds that it does not have jurisdiction over this issue for United Hospital, West Virginia University Hospital and City Hospital. The Board finds that the Providers' challenge to the DSH SSI regulation and statute is properly pending in a CIRP group. With respect to the request for a realignment, the Board finds that it does not have jurisdiction over this portion of the issue and hereby dismisses it from the above-referenced individual appeals. As there are no other issues, PRRB case numbers 16-1028, 16-0005 and 16-0578 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:
Gregory H. Ziegler, CPA, CPC-A
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.

FOR THE BOARD



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

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

cc: James Ravindran, Quality Reimbursement Services, Inc.
Laurie Polson, Palmetto GBA c/o National Government Services (J-M)
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

CERTIFIED MAIL

MAY 3 0 2018

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

RE: Paradise Valley Hospital, Provider No. 03-0083, FYE 12/31/2000, Case No. 17-0060

Dear Mr. Summar:

The Provider Reimbursement Review Board has reviewed the above-captioned appeal. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts

Paradise Valley Hospital, which is commonly controlled by Community Health Systems (CHS), was a participant in the CHS 1999-2000 DSH Medicare+Choice Days CIRP Group, case number 08-0861GC.[1] The group appeal was administratively resolved on March 1, 2016 and was closed by the Board on March 8, 2016.

In response to the Administrative Resolution of the group, the Medicare Contractor issued a Notice of Reopening for fiscal year ending ("FYE") 12/31/2000 for the subject Provider on April 1, 2016. In it, the Medicare Contractor advised that it would review "additional Part C Eligible Days (and total days, if necessary) used in the calculation of the Disproportionate Share Hospital (DSH) Adjustment."

A Notice of Correction of Program Reimbursement ("RNPR") was issued to the Provider on April 8, 2016.

On October 11, 2016, CHS filed an individual appeal on behalf of the Provider from the RNPR dated April 8, 2016, to which the Board assigned case number 17-0060. The Provider listed a single issue in the appeal request:

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

The Medicare Contractor submitted a jurisdictional challenge on April 26, 2018. In it, the Medicare Contractor objects to the Board's jurisdiction over the SSI Provider Specific issue because the hospital has not yet made a decision to realign its SSI percentage with its fiscal year end – thus there has been no Medicare Contractor determination from which it can appeal.

Before ruling on the jurisdictional challenge, the Board sent a request for additional information

[1] The Provider transferred the issue from its individual appeal at the time, case number 04-0991, which was filed on March 15, 2004 from a NPR dated September 17, 2003.

to the Parties. The Medicare Contractor replied by sending copies of the Medicare Contractor's Notice of Reopening, Audit Adjustment Pages dated March 15, 2016 and August 27, 2015, the Revised Settlement Memorandum in case number 08-0861GC and a copy of the Administrative Resolution in that group.

Board Determination:

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

In this case, the Provider filed its appeal from a RNPR.

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

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

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

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

Therefore, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue in this case. As noted, the cost report was reopened to revise additional Part C Eligible Days, not SSI. Although there is an adjustment to the SSI percentage at Adjustment 6, there was no

change between the cost reports issued on August 27, 2015 and on March 15, 2016 (both of which show 4.17 on Worksheet E, Part A).

As there are no other issues for adjudication, the Board hereby dismisses the issue and closes the case. 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.

FOR THE BOARD

Board Member

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

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

cc: Byron Lamprecht, Wisconsin Physicians Service (J-5)
Wilson C. Leong, Esq., CPA, Federal Specialized Services