DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Leslie Goldsmith, Esq.
Baker, Donelson Bearman Caldwell & Berkowitz
100 Light Street
Baltimore, MD 21042

RE: ***EJR Determination***
Case No. 20-1595GC Univ of Rochester CY 2016 DGME Penalty to FTE Count CIRP Group
Case No. 20-2063GC Northwell Health CYs 2014-2015 DGME FTE Cap CIRP Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' October 1, 2021 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeals.[1] The decision of the Board is set forth below.

Issue in Dispute

The Providers' group issue statement describes the DGME Penalty issue as follows:

> Whether the Medicare Administrative Contractor ("MAC") must correct its determinations of the Provider's cap of full-time equivalent ("FTE") residents and the weighting of residents training beyond the initial residency periods ("IRPs") used for determining payments for direct graduate medical education ("DGME").
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> The Medicare statute caps the number of DGME FTEs that a provider may claim, 42 U.S.C. § 1395ww(h)(4)(F), and also weights DGME FTEs at 0.5 for residents who are beyond the IRP, 42 U.S.C. § 1395ww(h)(4)(C). The Provider disputes the computation of the current, prior and penultimate weighted DGME FTEs and the FTE cap. CMS's implementation of the cap and weighting factors is contrary to the statute, because it imposes on the Provider a weighting factor of greater than 0.5 for residents

[1] The EJR Request also listed 7 other CIRP group appeals and 1 optional group appeal. However, as some or all of the participants in these 8 other group appeals have cost reporting periods beginning on or after January 1, 2016 and are thereby subject to the cost reporting claim requirements at 42 C.F.R. §§ 413.24(j) and 405.1873(a), the Board is responding to the EJR request as it relates to these 8 other group appeals under separate cover.

> who are beyond the IRP and prevents the Provider from claiming FTEs up to its full FTE caps. See 42 C.F.R. § 413.79(c)(2). The regulation at 42 C.F.R. § 413.79(c)(2) is, therefore, invalid, and the MAC must recalculate the Provider's DGME payments consistent with the statute so that the DGME caps are set at the number of FTE residents that the Provider trained in its most recent cost reporting period ending on or before December 31, 1996, and residents beyond the IRPs are weighted at no more than 0.5. The Provider self-disallowed the amount at issue, because the MAC was bound to deny payment pursuant to the regulation at 42 C.F.R. § 413.79(c)(2), and the Provider challenges that regulation. See CMS-1727-R.

Background

The Medicare statute requires the Secretary[2] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[3] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[4]

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[5]

These appeals concern the first component of the DGME payment calculation—the resident FTE count.

A hospital's FTE count for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. § 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---

[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395ww(h).
[4] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[5] 42 U.S.C. § 1395(h).

> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[6] ("*IRP residents*") are weighted at 100 percent or 1.0, while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "*fellows*") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[7] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three-year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

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[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).

[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[9] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> • *Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
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> *****

[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1*. Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
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> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[12]
> 11<

To codify this change, the Secretary added clause (iii) to 42 § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R.

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 66 Fed. Reg. 39826 (Aug. 1, 2001).
[12] *Id.* at 39894 (emphasis added).

§ 413.79(c)(2)(iii).[13] This regulation is the focus of these appeals and this EJR request, and it states the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

As previously noted, this regulation addresses how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility that year.[15]

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[16]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, is averaged with the FTE counts from the prior and penultimate years.

The Providers' Position

The Providers are teaching hospitals that receive DGME payments and, during the cost years under appeal, their FTE counts exceeded their FTE caps.[17] The Providers also trained fellows

[13] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that was in the prior version of the regulation and replacing it them with reference to "the limit described in this section."
[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")
[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] Providers' Petition for Expedited Judicial Review at 8 (Oct. 1, 2021) ("EJR Request").

and other residents who were beyond the IRP. The Providers are requesting the Board grant EJR based on a challenge to:

> the validity of the regulation at 42 C.F.R. § 413.79(c)(2) implementing the [DGME] cap on [FTE] residents and the FTE weighting factors. The regulation at 42 C.F.R. § 413.79(c)(2) is contrary to the statute because it determines the cap after application of weighting factors. The effect of the unlawful regulation is to impose on the Providers a weighting factor that results in a reduction of greater than 0.5 for many residents who are beyond the initial residency period ("IRP"), and it prevents the Providers from claiming their full unweighted FTE caps authorized by statute (hereinafter, the "fellowship penalty"). Thus, the calculation of the current, prior-year, and penultimate-year weighted DGME FTEs and the FTE caps is contrary to the statutory provision at 42 U.S.C. § 1395ww(h), and, as a result, the Providers' DGME payments are understated.[18]

The Providers argue that the applicable statute at 42 U.S.C. § 1395ww(h)(4) caps the number of residents that a hospital may claim at the number it trained in cost years ending in 1996, that the weighting factor is 0.50 for residents beyond the IRP, and that the current year FREs are capped before application of weighting factors.[19] They claim that CMS' regulation at 42 C.F.R. § 413.79(c)(2)(ii)-(iii) is contrary to this statute because it determines a cap after application of the weighting factors to fellows in the current year.[20] Second, they argue that CMS' weighted FTE cap "prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows[,]" and that two hospitals with identical 1996 FTE caps would be treated differently if one trained even a partial FTE fellow.[21] Finally, Providers claim "the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute."[22]

The Providers allege that, even if CMS' regulation was consistent with the controlling statute, it is arbitrary and capricious because it prevents the Providers from reaching their FTE caps and treats similarly situated hospitals differently.[23] Finally, the Providers state that the U.S. District Court for the District of Columbia has already ruled that CMS' regulation is contrary to law.[24]

The Providers claim that they meet the jurisdictional dissatisfaction requirement for this issue pursuant to CMS Ruling 1727-R and because they self-disallowed the amount sought based on the Medicare Contractor being bound by regulation.[25] They argue that the Board lacks the authority to decide the validity of CMS' regulation establishing the DGME fellowship penalty implemented through 42 C.F.R. § 413.79(c)(2) and thus should grant their request for EJR.[26]

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[18] *Id.* at 1 (citations omitted).
[19] *Id.* at 11.
[20] *Id.* at 11-12.
[21] *Id.* at 12-13.
[22] *Id.* at 14.
[23] *Id.* at 16.
[24] *Id.* at 17 (citing *Milton S. Hershey Med. Ctr. v. Becerra*, No. 19-2628 (May 17, 2021).
[25] *Id.* at 8.
[26] *Id.* at 17-18.

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) (2011), 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.

A. *Appeals of Cost Report Periods Beginning Prior to January 1, 2016*

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after 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* ("*Bethesda*").[27] 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.[28]

On August 21, 2008, new regulations governing the Board were effective.[29] 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*").[30] 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.[31]

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

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[27] 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.).
[28] *Bethesda*, 108 S. Ct. at 1258-59.
[29] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[30] 201 F. Supp. 3d 131 (D.D.C. 2016).
[31] *Id.* at 142.

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 the Providers in Case Nos. 20-1595GC and 20-2063GC, involved with the instant EJR request, involve cost report periods which began prior to January 1, 2016 and are governed by CMS Ruling CMS-1727-R. In addition, the Providers' jurisdictional documentation shows that the estimated amount in controversy exceeds $50,000 in each case, as required for a group appeal.[32] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Board's Analysis of the Appealed Issue

The Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between residents in their initial training period and fellows. The Providers assert that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this formula results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Providers present the following equation in its request for EJR used to calculate the allowable count for primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}\,[33]$$

Accordingly, the Board set out to confirm the Providers' assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[34] As such, the equation would logically appear to be a

[32] *See* 42 C.F.R. § 405.1839.
[33] EJR Request at 4.
[34] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's

method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[35] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the Providers that § 413.79(c)(2)(iii) essentially states the above equation, albeit in a slightly different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) states:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[36]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[37] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[38] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the

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weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).

[35] 66 Fed. Reg. at 39894 (emphasis added).

[36] (Emphasis added.)

[37] *See* 62 Fed. Reg. at 46005 (emphasis added).

[38] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).

operation of the following simple algebraic principle of equivalent fractions[39] (*i.e.*, ratios) using variables a, b, c, and d:

$$If\ \frac{a}{b} = \frac{c}{d}\ then\ \text{c} = \frac{a}{b}\ x\ d$$

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[40]

On the other side of the algebraic equation (*i.e.*, the ratio of "c / d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same proportion." This phrase expressed as a ratio ("c/d") is an *unknown* Weighted FTE Cap over the FY's Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

$$\frac{Weighted\ FTE\ Cap\ (c)}{FY's\ Weighted\ FTE\ Count\ (d)} = \frac{Unweighted\ \ FTE\ Cap\ (a)}{FY's\ Unweighted\ FTE\ Count\ (b)}$$

The unknown Weighted FTE Cap (variable "c") is then determined by a/b x d. In other words, the unknown Weighted FTE Cap is determined by the following formula:

$$\boldsymbol{Weighted\ FTE\ cap} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times\ Weighted\ FTE\ Count$$

This formula is clearly stated in the preambles to both the FYs 1998 and 2002 IPPS Final Rules as previously quoted.

Based on the above, the Board finds that 42 C.F.R. § 413.79(c)(2)(iii) does set forth the equation being challenged and, accordingly, that the Providers are challenging the validity of § 413.79(c)(2)(iii). Since 42 C.F.R. § 405.1867 requires that the Board comply with the requirements of the statute and regulations, the Board lacks the authority to eliminate the regulatory provision that creates the alleged penalty in § 413.79(c)(2)(iii) which is the remedy

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[39] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

[40] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

the Providers are seeking. Consequently, EJR is appropriate for the issue under dispute in these cases.

C. 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 Providers in this appeal are entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), 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. § 413.79(c)(2)(iii) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) 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.

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

10/18/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

Enclosure: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

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

RE: ***EJR Determination***
Hall Render CY 2016 DSH SSI Dual Eligible Days Group
Case No. 19-2554G

Dear Ms. Griffin:

On July 22, 2021, the Provider Reimbursement Review Board ("Board") issued a Scheduling Order for the setting deadlines for the filing of any substantive claim challenges made pursuant to 42 C.F.R. § 405.1873(a) in the above-referenced appeals. The parties filed responses on August 20, 2021 and September 24, 2021. The decision of the Board with respect to the substantive claim matter and EJR is set forth below.

Application of 42 C.F.R. § 405.1837(b)(1):

The regulation, 42 C.F.R. § 405.1837(b)(1)(i), mandates the issue of group appeals where:

> 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.

In its July 22nd development letter the Board asked the Group Representative to determine if Truman Medical Center (Prov. No. 26-0048) and Ohio State University Health System (Prov. No. 26-0085) were common issue related party (CIRP) Providers subject to the above CIRP regulation for the period at issue. The Group Representative responded by stating that the only other hospital related to Truman Medical Center was Truman Lakewood and it did not appeal DSH from its 2016 NPR. With respect to Ohio State University Hospital, the Group Representative stated that the only related Provider is Arthur James Cancer Hospital which is not eligible for DSH payments. Consequently, the Group Representative did not believe CIRP groups needed to be established for these hospitals.

As a result, of these representations that there are no other commonly owned or controlled providers related to them that will pursue the group issue for CY 2016, the Board finds that Truman Medical Center and Oh State University Health System may remain in the optional

group. However, *be aware that neither the Truman Health System (including Truman Lakewood) nor Ohio State Univerysity Health System may not further puruse this issue for CY 2016 (whether in an individual appeal, a CIRP group appeal or another optional group)*.[1]

Issue for which EJR is Requested:

The Providers,in the above-referenced group appeal are requesting EJR for the following issue:

> The days at issue in these appeals are days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in these appeals is whether the Intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction" for purposes of calculating the Provider's [Disproportionate Share Hospital ("DSH")] payment, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."
>
> The Providers respectfully assert that under the rules of statutory construction CMS is *compelled to interpret "entitlement to SSI" benefits to include all inpatients who were eligible for and/or enrolled in the SSI program at the time of their hospitalization* ***and***, further, to *furnish Providers with a listing of those SSI Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare Act*. Furthermore, [t]he Providers seek a ruling that CMS has failed to provide the them with adequate information to allow them to check and challenge CMS'[] disproportionate patient percentage ("DPP") calculations. The Providers are entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173. . . . Because the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of

[1] In the final Board Rules published in the May 23, 2008 Federal Register, the Secretary stated that:

> Our interpretation of the statute is that commonly owned or operated providers must bring "a" group appeal on the same issue. If the Congress had intended to permit separate group appeals, it could have said that the appeal must be brought by "one or more groups." Therefore, at this time, we believe we are constrained to require that commonly owned or operated providers bring only one group appeal for the same issue (regarding cost reporting periods ending in the same calendar year).

73 Fed. Reg. 30190, 30213 (May 23, 2008). To that end, the Secretary enacted the regulation, 42 C.F.R. § 405.1837(b), which requires that:

> (1) Mandatory use of group appeals.
> (i) 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.

> the hospital's Medicare patients who are enrolled in SSI and/or eligible for SSI benefits along with their corresponding SSI status codes, and does not give the Providers any meaningful means of challenging the SSI days chosen by CMS to be used in Provider's DPP calculations, CMS continually violates its § 951 mandate . . . .[2]

Medicare Disproportionate Share Hospital (DSH) Payment Background:

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[3] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[4] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[5] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and

[2] EJR Request at 2-3 (emphasis added).
[3] 42 C.F.R. Part 412.
[4] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[5] (Emphasis added.)

> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[7] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[8] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[9]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[10] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[11]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[12] and may terminate,[13] suspend[14] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[15] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[16]
2. The individual fails to apply for other benefits to which the individual may be entitled;[17]

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[6] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[7] 42 U.S.C. § 1382.
[8] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[9] 20 C.F.R. § 416.202.
[10] 42 U.S.C. § 426.
[11] 42 U.S.C. § 426-1.
[12] 20 C.F.R. § 416.204.
[13] 20 C.F.R. §§ 416.1331-1335.
[14] 20 C.F.R. §§ 416.1320-1330.
[15] 20 C.F.R. § 1320.
[16] 20 C.F.R. § 416.207.
[17] 20 C.F.R. § 416.210.

3. The individual fails to participate in drug or alcohol addiction treatment;[18]
4. The individuals is absent from the United States for more than 30 days;[19] or
5. The individual becomes a resident of a public institutions or prison.[20]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[21]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[22] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[23] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[24] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[25] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[26]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[27]

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[18] 20 C.F.R. § 416.214.
[19] 20 C.F.R. § 416.215.
[20] 20 C.F.R. § 416.211.
[21] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[22] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[23] *Id.*
[24] *Id.*
[25] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[26] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[27] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[28] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[29] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[30]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[31] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[32]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[33] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided

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zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[28] CMS-1498-R at 5.

[29] *Id.*

[30] *Id.* at 5-6.

[31] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

[32] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").

[33] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[34] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[35] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[36] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[37]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[38] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[39] In the FY 2111 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[40]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[41]

As a result of the Rulings, new regulation, and new data match process, CMS calculated SSI percentages for the Providers for all of fiscal years at issue in this CIRP group appeal.[42] The

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[34] *Id.* at 50280.
[35] *Id.* at 50280-50281.
[36] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[37] *Id.* at 50285.
[38] CMS-1498-R at 6-7, 31.
[39] *Id.* at 28, 31.
[40] 75 Fed. Reg. at 24006.
[41] CMS-1498-R2 at 2, 6.
[42] CMS published the SSI ratios for FY 2012 on or about June 12, 2014. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

Providers have appealed original NPRs a based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

Providers' Request for EJR:

The Providers assert that, under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration ("SSA") for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[43]

The Providers note that, in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the FY 2011 IPPS Final Rule that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[44] Thus, the Providers allege the exclusion of the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the DSH statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' disproportionate patient percentage ("DPP") calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA").[45]

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

[43] 75 Fed. Reg. at 50275-86.
[44] *Id.* at 50281.
[45] Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).

challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

A. Jurisdiction

1. Jurisdiction For Participants with Fiscal Years Begninnin Prior to January 1, 2016

The participants that comprise the group appeal within this EJR determination, have filed appeals involving calendar year 2016. This section addresses Board jurisdiction over those participants in Case no. 19-2554G with fiscal years beginning ***prior to*** January 1, 2016.

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 DSH SSI Dual Eligible Days issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[46] 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.[47]

On August 21, 2008, new regulations governing the Board were effective.[48] 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*").[49] 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.[50]

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

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[46] 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.).
[47] *Bethesda*, 108 S. Ct. at 1258-59.
[48] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[49] 201 F. Supp. 3d 131 (D.D.C. 2016).
[50] *Id.* at 142.

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.

With respect to the participants in this case that filed appeals of cost reporting periods being ***prior to*** January 1, 2016, the Board finds, based on its review of the record, that these the appeals were timely filed, these appeals are governed by CMS Ruling 1727-R, and these appeals are permitted under that Ruling as they are challenging the substantive and procedural validity of a regulation.[51]

2. Jurisdiction and Appropriate Cost Report Claim Summary for the Remaining Participants With Fiscal Years Beginning on January 1, 2016

The remaining participants in 19-2664G have cost report periods beginning ***on*** January 1, 2016, these appeals were also timely filed. The Board notes that the November 13, 2015 OPPS Final Rule *eliminated* the ***jurisdictional*** requirement of provider dissatisfaction in existing §§ 405.1835(a)(1) and 405.1840(b)(3) for Board appeals of cost reporting periods beginning on or after January 1, 2016.[52] Based on its review of the record, the Board finds that each of these Providers filed timely and proper appeals to be directly added to the group and that the Board has substantive jurisdiction over the issue appealed (*i.e.*, it has not been excluded from administrative review by). Accordingly, the Board finds that it has jurisdiction over these participants.

3. Jurisdiction over the Group

The participants' documentation in the EJR request shows that the estimated amount in controversy exceeds $50,000 in the group, as required for a group appeal.[53] Further, the group issue is not otherwise precluded from administrative review. The Board finds that it has jurisdiction for the above-captioned group appeal as well as the underlying providers (as explained in Sections A.1 and A.2 *supra*). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Appropriate Cost Report Claim Summary for the Participants With Fiscal Years Beginning On January 1, 2016

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[54] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this*

[51] *See* 42 C.F.R. § 405.1835(a)(3).
[52] 80 Fed. Reg. 70298 (Nov. 13, 2015).
[53] *See* 42 C.F.R. § 405.1837.
[54] (Emphasis added.)

a requirement for reimbursement, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

On July 22, 2021, the Board sent the parties a letter noting that in the case referenced above, one or more of the participants had cost reporting period beginning on or after January 1, 2016, and as a result the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. Both parties have responded to the Board's query as to the applicability of the regulations to the Providers in this case. The Board notes that, while there are 6 particpants in Case No. 19-2554G that have fiscal years beginning on January 1, 2016, the Medicare Contactor only filed substantive claim challenges for 3 of these participants.[55] Neither party requested that the Board conduct an oral proceeding on the substantive claims challenges.[56]

1. Regulatory Background on the Cost Report Substantive Claim Requirement

For cost report periods beginning on or after January 1, 2016, the regulations 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j) requires that:

> 1) *General requirement.* In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—
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> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.

[55] The Board's use of the term "Substantive Claim Challenge" simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items.
[56] In its July 22, 2021 request for information, the Board advised the parties: "If a party desires to have additional evidence or argument considered (e.g., testimony or oral argument), that party must submit a request to the Board with both a description of and an explanation of the need for such additional evidence/argument (whether written or oral). Otherwise, following the above referenced filing deadline, the Board will proceed with issuing a ruling on § 413.24(j) compliance issue(s) based solely on the record before it."

> (2) Self-disallowance procedures. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

In conjunction with the regulation, above, 42 C.F.R. § 405.1873(a) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.
>
> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the**

> **Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[57]

These regulations are applicable to the cost reporting period of multiple group participants in this case. Following the Board's July 22, 2021 Request for Information, the parties submitted briefs with regard to whether the Providers included an appropriate ***cost report*** claim for the disputed issue.

2. Substantive Claim Challenges[58] Filed By the Medicare Contractor

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[59] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included with the as-filed cost report at issue, ***when a party questions*** whether, pursuant to 42 C.F.R. § 405.1873(a), a provider "included an appropriate claim for the specific item" under appeal in the cost report at issue.

The Board notes that there are multiple participants in this group that have cost reports beginning on or after January 1, 2016 and are, thereby, subject to the "Substantive reimbursement requirement of an appropriate cost report claim" delineated in 42 C.F.R. § 413.24(j). However, a question regarding these participants compliance with the requirement has only been raised with respect to 3 of these participants –Baxter County Regional Hospital, Major Hospital and Bryan Medical

[57] (Bold and underline emphasis added.)
[58] *See supra* note 55.
[59] (Emphasis added.)

At the outset, the Board notes that, since neither party raised such a question with respect to the the remaining Providers, no Board inquiry is triggered under 42 C.F.R. § 405.1873(b). Accordingly, the Board is ***not*** required to review (nor include any findings) on that question and so the Board includes no such findings herein regarding the remaining Providers.

3. Medicare Contractor's Substantive Claim Challenge

The Medicare Contractor filed Substantive Claim Challenges for 3 participants in Case No. 19-2554G. Specifically, the Medicare Contractor contends that the following three Providers failed to properly claim or protest reimbursement for the DSH SSI Ratio Dual Eligible days issue on their respective cost reports and that none of the exceptions in 42 C.F.R. § 413.24(j)(3)(i)-(iii) apply:

Participant #1 – Baxter County Regional Hospital (Prov. No. 04-0027, FYE 12/31/2016);
Participant #4 – Major Hospital (Prov. No. 15-0097, FYE 12/31/2016); and
Participant #6 – Bryan Medical Center (Prov. No. 28-0003, FYE 12/31/2016).

For Particpant #1, Baxter County Regional Hospital ("Baxter"), the Medicare Cotnractor contends that there is nothing in the record to show that Baxter attempted to claim the disputed item for full reimbursement following a belief that the items comported with Medicare policy. The Provider identified adjustments 39, 40, and 41 as the subject of the appeal. Adjustment 39 reduced the percentage of SSI recipient patient days to Medicare Part A patient days to align with the published SSI percentage. Adjustment 40, the DSH percentage was reduced. Adjustment 41 removed $154,596 protested items. The Medicare Contractor maintains that the supporting description of the protest amounts reveals that Baxter did not establish a self-disallowed item for DSH-SSI Dual Eligible days because the Provider did not attach a *separate worksheet* for each specific self-disallowed item describing how the Provider calculated the estimated reimbursement amount for each self-disallowed item. Accoridnlgy, the Medicare Contractor concluded that Baxter did *not* properly self-disallow the item as described at 42 C.F.R. § 413.24(j)(2) and that none of the exceptions at subsections (3)(i) through (3)(iii) apply.

For Particpant #4, Major Hospital, the Medicare Contractor points out that the Provider identified adjustments 5 and 30 as the subject of this appeal. Adjustment 5 adjusted the SSI percentage and allowable DSH percentage. Adjustment 30 removed Part A protested amounts of $2,013,745. The Medicare Contractor contends that the adjustments do not indicate that Major Hospital sought to claim full reimbursement for DSH-SSI Dual Eligible days. The Medicare Contractor recognizes that Major Hospital submitted a summary of its protested items along with its cost report but contends that Major Hospital failed to attach a ***separate*** *work sheet* for ***each*** specific self-disallowed item that: (1) explained why it self-disallowed the item; and (2) described how it calculated the estimate reimbursement amount for each self-disallowed item. Accoridnlgy, the Medicare Contractor concluded that Major Hospital did *not* properly self-disallow the item as described at 42 C.F.R. § 413.24(j)(2) and that none of the exceptions at subsections (3)(i) through (3)(iii) apply.

For Participant #6, Bryan Medical Center ("Bryan"), the Medicare Contractor states that Bryan Medical Center identified Audit Adjustment No. 38 as the subject of the appeal. This adjustment removed Part A protested amounts totaling $24,579,162. The Medicare Contractor maintains that there is no indication that the Provider sought to claim the full amount of reimbursement for DSH-SSI Dual Eligible Days. The Medicare Conractor further notes that, while Bryan submitted a summary of its protested items along with its cost report, it failed to attach a ***separate*** work sheet for ***each*** specific self-disallowed item, both explaining why it self-disallowed each specific item and describing how it calculated the estimated reimbursement amount for each specific self-disallowed item. Accoridnlgy, the Medicare Contractor concluded that Bryan did *not* properly self-disallow the item as described at 42 C.F.R. § 413.24(j)(2) and that none of the exceptions at subsections (3)(i) through (3)(iii) apply.

4. The Providers' Response to the Substantive Claim Challenge

For Particpant #1, Baxter, the Representative maintains the Provider claimed SSI Dual Eligible Days as a Protested amount on its as-filed cost report and references Exhibit P-1 in support of this assertion. The Representative contends that Baxter included with its as-filed cost report a worksheet with a narrative and calculation which includes a protest for SSI Days which is included as "we have included the Medicare DSH calculation an estimate of days for patients who (for such days were entitled to benefits under Medicare Part A or Medicare+Choice and were entitled to Federal supplemental security income benefits (Exhibit P-1, page 3). In the narrative associated with that worksheet, Baxter maintains that the calculation for dual eligible days cannot be determined by the Provider since the Social Security Administration and CMS bar access to this information.

For Participant #4, Major Hospital, the Representative maintains that the Provider submitted with its as-filed cost report a SSI Dual Eligible Days through a printed version of Excel workbook that was submitted with the jurisdictional documentation it inadvertently omitted the narrative accompanying the dual eligible calculation due to a printing error. The Provider included this in Exhibit P-3.

For Particpant # 6, Bryan, the Representative asserts that the Provider claimed SSI dual eligible days on its as-filed cost report as a protested amount and references Exhibit P-4 in support of this assertion. The Provider states that documentation included with the as-filed cost report includes both a narrative and a calculation supporting this "Protested Item" claim for reimbursement. The Representative states that the Excel workbook that was submitted with its as-filed cost report was inadvertently omitted from the jurisdictional documents and is not found in Exhibit P-5.

The Representative goes on to present an alternaive argument to challenge the validity of the regulations governing substantive claims. Specifically, the Representative asserts that the Medicare Contractor filed a substantive claim challenge suggesting that the Providers are subject to the "substantial claim" requirements of 42 C.F.R. §§ 413.24(j) and 405.1873, effective with cost reporting periods beginning on or after January 1, 2016. However, the Representative note that, for periods prior to the January 1, 2016 period, nearly identical regulatory policies were

stricken by the Federal courts in *Bethesda Hospital Association v. Bowen* ("*Bethesda*")[60] and *Banner Heart Hospital v. Burwell* ("*Banner*").[61] The Representative contends that, pursuant to 42 U.S.C. § 1395oo(a), the Providers need only to be dissatisfied with the final determination of the Medicare Contractor and meet the monetary threshold for Board jurisdiction in order to pursue an appeal before the Board.

5. The Board's Factual and Legal Findings on the Substantive Claim Challenges

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[62] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included ***when a party questions*** whether, pursuant to 42 C.F.R. § 405.1873(a), a provider "included an appropriate claim for the specific item" under appeal in the cost report at issue.

The Board notes that the following 6 participants in this optional group have cost reports beginning on January 1, 2016 and are, thereby, subject to the "Substantive reimbursement requirement of an appropriate cost report claim" delineated in 42 C.F.R. § 413.24(j): Baxter, Major Hospital, Bryan, Henry County Memorial, Good Samaritan Hospital, and Wooster Community Hospital. However, a question regarding these participants compliance with the requirement has only been raised with respect to 3 of these participants – Baxter, Major Hospital and Bryan.

At the outset, the Board notes that, since neither party raised such a question with respect to Henry County Memorial, Good Samaritan Hospital, and Wooster Community Hospital, no Board inquiry is triggered under 42 C.F.R. § 405.1873(b). Accordingly, the Board is ***not*** required to review (nor include any findings) on that question and so the Board includes no such findings herein regarding Henry County Memorial, Good Samaritan Hospital, and Wooster Community Hospital.

Further, with regard to Baxter, Major Hospital, and Bryan, the Board recognizes that the Group Representative has raised arguments challenging the *substantive* validity of 42 C.F.R. §§ 413.24(j) and 405.1873 and that, as the Board is otherwise bound by these regulations, it does not have the authority to decide those legal questions. However, those arguments are made ***in the alternative***. For Baxter, Major Hospital, and Bryan, the Group Representative *first* argues that, contrary to the Medicare Contractor's assertion, they actually met the requirements of these regulations. Accordingly, EJR of these in-the-alternative arguments is *not* appropriate because the Board must resolve and issue a decision on the factual dispute between the parties on whether those requirements were met. The Board notes that review of the Board's factual and legal findings regarding that dispute may be available pursuant to 42 C.F.R. §§ 405.1842(g) and

[60] 485 U.S. 399, 400 (1988).
[61] 201 F.Supp. 3d 131, 133 (D.D.C. 2016).
[62] (Emphasis added.)

405.1875(a)(2)(v) and that such review necessarily would encompass the Group Representative's in-the-alternative arguments regarding the substantive validity of 42 C.F.R. §§ 413.24(j) and 405.1873.[63] Accordingly, the Board has set forth below its factual and legal findings on that question regarding these three participants, Baxter, Major Hospital and Bryan.

For Participant #1, Baxter, and Participant # 6, Bryan, the Board finds that they each failed to meet the requirement in 42 C.F.R. § 412.24(j)(2)(ii) to "[a]ttach a ***separate*** work sheet to the provider's cost report *for* ***each*** *specific self-disallowed item*, ***explaining why*** the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) ***and describing how*** the provider calculated the estimated reimbursement amount for each specific self-disallowed item."[64] Rather, the documentation furnished by the representative shows only a conglomerated calculation for the multiple protested amounts that cannot be tied to each of the protested items.

In particular, for Baxter, the record shows that the Representative submitted documentation in support of its contention that Baxter satisfied the "[s]ubstantive reimbursement requirement of an appropriate cost report claim" for the group issue. This documentation was submitted as part of the jurisdictional documentation filed with the Schedule of Providers as shown at Exhibit C-2. The Representative did not include any additional documentation as part of its response to the Medicare Contractor's Substantive Claim Challenge for Baxter (*i.e.*, Exhibit P-1 attached to that response is a subset of the documentation included at Exhibit C-2). The documentation does include a listing of ***multiple*** protests for "specific item[s]" and the group issue appears as one of multiple protests in the section entitled "SSI Days." The issues included in the SSI Days section includes *Baystate* data matching process issues as well as the position that the definition of SSI days be expanded or, if not, the alternative separate and *legally opposite* position that Part C days and exhausted dual eligible days be ***excluded*** from the Medicare fraction. The one page table calculates a cumulative impact in "Protest for SSI Days" of $31,052 and for all protested items of $154,596. However, the Board cannot identify what the estimated impact of the group issue is from these materials to segregate out the estimated impact of the group issue from the estimated impact of the *Baystate* data mathing process issue from estimatd impact of the alternative but *legally* separate opposite position to ***exclude*** exhausted dual eligible days and Medicare Part C days from the Medicare fraction. Accordingly, it is clear that Baxter failed to meet the requirement in 42 C.F.R. § 412.24(j)(2)(ii). Further, none of the exceptions in § 412.24(j)(3) apply since there is no amended cost report or reopening and none of the adjsutments in the NPR adjusted for the specific item that is the group issue.[65]

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[63] Note that Administrator review under 42 C.F.R. § 405.1875(a)(2)(v) is referenced in § 405.1842(g). *See also* 42 C.F.R. § 405.1873(f)(2).

[64] (Empahsis added.)

[65] In Baxter's appeal request, the Representative references Audit Adjustment Nos. 39, 40, and 41; howver, Audit Adjustment No. 39 updated the SSI percentage, Audit Adjustment No. 40 updated the DSH calcualton based on the new SSI percentage, and Audit Adjustment No. 41 removed the protested items. Note of these adjustments specifically adjusted for the group issue to remove it from the as-filed cost report (i.e., Baxter did not claim, in accordance with Medicare policy, full reimbursement for the group issue only to have it adjusted off and removed by the Medicare Contractor).

In particular, for Bryan, the record shows that the Representative submitted documentation in support of its contention that Baxter satisfied the "[s]ubstantive reimbursement requirement of an appropriate cost report claim" for the group issue. This documentation was submitted as part of the jurisdictional documentation filed with the Schedule of Providers as shown at Exhibit C-4[66] and then as part of Exhibit P-5 which was submitted in response to the Medicare Contractor's Substantive Claim Challenge to supplement the record.[67] The documentation submitted originally with the Schedule of Providers consisted of the following two documents:

1. A "Protested Amounts & Items" summary consisting of 2 ***unnumbered*** pages that included multiple protested items totaling in the aggregate $24,579,162.32. The protested items include, among others, lines for "DSH Impact for Proper Riembursement (Dual Eligible, Medicare C, Medicare Non-Covered days, other)" for $4,421,53100; "SSI Proper number for reimbursemenet – Hospital and Rehab SSI" for $71,420.00; "Medicare/Medicaid Days in SSI" for 164,482.00; "Cumulative Operating and Captial DSH protested amounts" for $6,702,633.00; and "Capital Disproportionate share" for $427,735.00.

2. "Medicare Disporportionate Share – Shedule of Protested Amounts" consisting of one ***unnumbered*** page that included narrative descriptions of certain protested items entitled "Medicaid fration days"; "Medicare Part C/Part A Days Medicaid fraction"; Medicare Part C/Part A Days Medicare Fraction"; "SSI Entitlement"; "SSI Mechanical Deficiencies"; and "Uncompensated Care Calcualtion."

The Board was unable to reconcile or tie the first document with the second document and neither document described how the amounts in the first document were calculated and it is unclear what line in the first document pertains to the group issue (or whether some or all of the examples listed above pertain to the group issue). Notwithstanding, the Board notes that the first document's cumulative protested amount of $24,579,162 ties to Audit Adjustment No. 38 which removed the protrested items in this amount. The supplemental Exhibit P-5 included the second document listed above but as the second page ("Page 2 of 2") of a two-page Execl document. The frst page of the Excel document lists a cumulative maximum benefit of protested issues in the amount of $476,678 and one of the items included in this is a computation for SSI entitlement totaling $84,322 in culmulative effect. Howver, the none of the numbers included in the Exhibit P-5 Excel spreadsheet reconcile or tie with the summary included at Exhibit C-4 showing $24.5 million in cumulative protested items (as originally submitted with the jurisdictional documentation and which ties into Audit Adjustment No. 38). Accordinlgy, due to the mismatch and confict between documents submitted with the Scheudle of Providers (as showin in Exhibit C-4) and the supplemental Exhibit P-5, the Board questions whether the new document at P-5 (where one of the original unnumbered documents is now appearing numbered as page 2 of a 2 page document) was part of the as-filed cost report and, based on the record before it, cannot find that it was. Regardless, it is clear that Bryan failed to comply with the requirements at

[66] Note the coverpage suggests in error that it is Exhibit C-6. The header and List of Exhbiits confirms that it is Exhibit C-4.
[67] The Representative lists Exhibit P-5 as "Bryan's **inadvertently** *omitted* DSH detailed calculation submitted with its as-filed cost report for protested amounts." (Emphasis added.)

§ 413.24(j)(ii) of submitting a ***separate*** worksheet for ***each*** protested item and describing how the estimate reimbursement for each protested item was calculated.[68] Further, none of the exceptions in § 412.24(j)(3) apply since there is no amended cost report or reopening and none of the adjsutments in the NPR adjusted for the specific item that is the group issue.[69]

For Parcipant #4, Major Hospital, the record shows that the Representative submitted documentation in support of its contention that Major Hospital satisfied the "[s]ubstantive reimbursement requirement of an appropriate cost report claim" for the group issue. This documentation was submitted as part of the jurisdictional documentation filed with the Schedule of Providers as shown at Exhibit C-3[70] and then as part of Exhibit P-3 which was submitted in response to the Medicare Contractor's Substantive Claim Challenge to supplement the record.[71] The Medicare Contractor has not challenged the Representative's assertion that the supplemental documentation included at Exhibit P-3 was submitted with the as-filed cost report at issue nor has the Board identified anything in the record to contradict or raise concerns about that assertion. Accordingly, the Board accepts that assertion. The documnation at Exhibit C-5 and P-3, when combined, comply with directive in 42 C.F.R. § 413.24(j)(2), that to properly protest and "specific item" on the cost report, the provider "must": (1) "[i]nclude an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report" and (2) "[a]ttach a ***separate*** work sheet to the provider's cost report *for* ***each*** *specific self-disallowed item*, ***explaining why*** the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) ***and describing how*** the provider calculated the estimated reimbursement amount for each specific self-disallowed item."[72] Here, it is clear that Major Hospital protested the SSI days issue and has a separate worksheet calculating the reimbursement effect of this issue as being based on the addition of 389 SSI days to the numerator of the Medicare Fraction of the DSH calcualtion.

In summary, the Board concludes that, as part of their respective as-filed cost reports for 2016, Particpant #1, Baxter, and Participant #6, Bryan, ***failed*** to include "an appropriate claim for the ***specific*** item"[73] under appeal in this group – the DSH SSI/Dual Eligible Days issue and did not meet an exception and, thereby, failed to comply with 42 C.F.R. § 413.24(j). However, the Board finds that, as part of its 2016 as-filed cost report, #4 Major Hospital did include "an appropriate claim for the specific item" under appeal in this group – the DSH SSI/Dual Eligible Days issue in compliance with 42 C.F.R. § 413.24(j).

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[68] To this end, it is unclear whether the $84,322 listed in cumulative effect for SSI entitlement encompasses multiple protested items or not and does not tie anywhere to the summary sheet included at C-2 listing $24 million in total protested items..

[69] In Bryan's appeal request, the Representative references Audit Adjustment No. 38; howver, Audit Adjustemnt No. 38 simply removed the protested items. As a result, it is clear this adjustment did not adjust for the group issue.

[70] Note the coverpage suggests in error that it is Exhibit C-5. The header and List of Exhbiits confirms that it is Exhibit C-3.

[71] The Representative lists Exhibit P-3 as "Major's ***correctly*** printed schedules from Excel file with Protested Amounts that was submitted with its as filed cost report." (Empahsis added.)

[72] (Empahsis added.)

[73] 42 C.F.R. § 405.1873(a).

C. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a *revised* data match.[74] The Secretary also stated in the Ruling that, where cost reports had not been settled, those providers SSI fraction would be calculated using the *revised* data match process to be published through rulemaking.[75]

Contemporaneous with CMS Ruling 1498-R[76] the Secretary published a proposed IPPS rule[77] which proposed to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the 2011 Final IPPS Rule in which the Secretary explained that:

> . . . we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[78]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[79]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate

[74] CMS Ruling 1498-R at 27.
[75] *Id.* at 31.
[76] *Id.* at 5.
[77] 75 Fed. Reg. 23852, 24002-07.
[78] 75 Fed. Reg. at 50277.
[79] (Medicare) Enrollment Database.

> SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[80]

The Secretary did not incorporate the above new policy involving the revised data match process into the Code of Federal Regulations. However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a binding data match process to be used by the Medicare Contractors in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2). Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[81] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this CIRP group appeal.

D. Board's Decision Regarding the EJR Request

The Board makes the following findings:

1) The Board has jurisdiction over the matter for the subject year and that the participants in this case are entitled to a hearing before the Board.

2) Questions were raised under 42 C.F.R. § 405.1873(a) regarding whether three participants complied with the appropriate cost report claim requirements in 42 C.F.R. § 413.24(j) and, after considering the parties filings related thereto, the Board finds that Participant #4 – Major Hospital (Prov. No. 15-0097, FYE 12/31/2016) was subject to and met the substantive cost report claim requirements in 42 C.F.R. § 413.24(j) while, in contrast, Participant #1 – Baxter County Regional Hospital (Prov. No. 04-0027, FYE 12/31/2016) and Participant #6 – Bryan Medical Center (Prov. No. 28-0003, FYE

[80] 75 Fed. Reg. at 50285.
[81] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

12/31/2016) were subject to but failed to meet those same requirements and failed to qualify for an exception under § 413.24(j)(3).

3) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule there are no findings of fact for resolution by the Board;

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

5) It is without authority to decide the legal question of whether the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation (as adopted in the preamble to the 2011 Final IPPS Rule) 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:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA

For the Board:

10/22/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Bryan Lamprecht, WPS
Wilson Leong

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Ave, Ste. 570A
Arcadia, CA 91006

RE: ***Jurisdictional Decision***
QRS Quorum 2015 DSH Uncompensated Care Distribution Pool CIRP Group
Case No. 18-0594GC

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced common issue related party ("CIRP") group appeal. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The issue being appealed is a challenge to the Disproportionate Share Hospital ("DSH") payment for uncompensated care costs ("UCC"), which argues that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, specifically, in its calculation of Factors 1 and 2.[1] First, the Providers claim that CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA"). They say that providers had a lack of information during the initial rulemaking for rules regarding UCC payments, and as a result could not submit meaningful commentary on the proposed rules.[2] Second, the Providers state that CMS acted beyond its authority by failing to adhere to the *Allina*[3] decision. They argue that the base year statistic used to calculate the 2014 UCC payments (2011) was understated due to mistreatment of Part C days, and claim that *Allina* required a recalculation of the 2011 data since that case rendered CMS' policy regarding those days "null and void."[4]

The Board received a Jurisdictional Challenge filed by the Medicare Contractor on June 15, 2018, arguing that the Board's jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g).

[1] Group Issue Statement at 1.
[2] *Id.* at 1-2.
[3] *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[4] Group Issue Statement at 3.

Relevant Law and Analysis:

A. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. 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).[5]
>
> (B) Any period selected by the Secretary for such purposes.

B. Interpretation of Bar on Administrative Review

1. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"),[6] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[7] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, 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 D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[8] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they

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[5] 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.
[6] 830 F.3d 515 (D.C. Cir. 2016).
[7] 89 F. Supp. 3d 121 (D.D.C. 2015).
[8] 830 F.3d 515, 517.

are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[9]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[10]

2. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[11] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[12] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[13]

3. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[14] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[15] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[16] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a

[9] *Id.* at 519.
[10] *Id.* at 521-22.
[11] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[12] *Id.* at 506.
[13] *Id.* at 507.
[14] 514 F. Supp. 249 (D.D.C. 2021).
[15] *Id.* at 255-56.
[16] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).

subsequent cost report that was a full twelve months.[17] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[18]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[19]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[20] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[21] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[22]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which

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[17] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[18] *Id.*
[19] *Id.* at 262-64.
[20] *Id.* at 265.
[21] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[22] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).

requires a violation of a clear statutory command.[23] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

4. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[24] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[25] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[26] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[27] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[28]

Board Decision:

The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2015. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

Accordingly, the Board dismisses Case No. 18-0594GC and removes it from the Board's docket. The Board notes that its ruling is consistent with the D.C. Circuit's decision in *Tampa General*, *DCH v. Azar*, and *Ascension* and that these decisions are controlling precedent for the interpretation of 42

[23] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[24] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[25] *Id.* at *4.
[26] *Id.* at *9.
[27] 139 S. Ct. 1804 (2019).
[28] *Ascension* at *8 (bold italics emphasis added).

U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[29] 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:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA

For the Board:

10/22/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Administrators (J-5)

[29] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave NW
Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
13-1937GC Methodist HS 2008 DSH Medicaid Fraction Medicare Advantage Days CIRP Grp
18-1036GC Methodist Health System 2011 DSH Medicare Advantage Days CIRP Group
18-1406GC Henry Ford Health System 2013 DSH Medicare Advantage Days CIRP Group
18-1516GC Allina Health 2013 Medicare Advantage Days CIRP Group
20-1866 Methodist Dallas Medical Center (Prov. No. 45-0051; FYE 06/30/2014)

Dear Ms. Webster:

The above-referenced common issue related party ("CIRP") group appeals and individual appeal[1] include a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before and after* October 1, 2013. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates *before* October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On September 30, 2021, the Providers in the above-referenced CIRP group appeals and individual appeal filed a joint request for Expedited Judicial Review ("EJR") of the Part C Days issue for FYEs 2008, 2011, 2013, and 2014.[2] The Providers request EJR over only the portion of their appeals challenging the application of the agency's 2004 rule to their Medicare part A/SSI fractions and Medicaid discharges reflected in the Medicaid fraction *prior* to October 1, 2013.[3]

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).
[2] Providers' Petition for Expedited Judicial Review (Sep. 30, 2021).
[3] *Id*.

Statutory and Regulatory Background

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[4] 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].[5]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[6]

With the creation of Medicare Part C in 1997,[7] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under

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[4] of Health and Human Services.
[5] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[6] *Id.*
[7] 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-

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 years 2001-2004.[8]

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 Medicaid 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 . . . .*[9]

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."[10] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[11]

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

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

[8] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[9] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[10] 69 Fed. Reg. at 49099.

[11] *Id.* (emphasis added).

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) 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 IPPS final rule was issued.[12] 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 adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[13] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[14]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[15] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[16] In *Allina Health Services v. Price* ("*Allina II*"),[17] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[18] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[19] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[20]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling

[12] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[13] *Id*. at 47411.
[14] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[15] 746 F. 3d 1102 (D.C. Cir. 2014).
[16] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[17] 863 F.3d 937 (D.C. Cir. 2017).
[18] *Id*. at 943.
[19] Id. at 943-945.
[20] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).

involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[21] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[22] The Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[23]

Regarding EJRs for this Issue, and the fate of these appeals, the ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
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> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand

[21] CMS Ruling 1739-R (Aug. 17, 2020).
[22] *Id*.
[23] *Id*.

> qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[24]

Providers' Request for EJR

The Providers within the CIRP group and individual appeals are challenging their Medicare reimbursement for the fiscal years 2008, 2011, 2013, and 2014 cost reporting periods. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[25] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[26] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[27] As such, the Providers conclude that the Board is "required" to grant EJR.[28]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[29] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[30]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here….[31]

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[24] CMS Ruling 1739-R at 6-7.
[25] Providers' Petition for Expedited Judicial Review at 1 (Sep. 30, 2021).
[26] *Id*.
[27] *Id*.
[28] *Id*. at 1-2.
[29] *Id*. at 14.
[30] *Id*. at 24.
[31] *Id*. at 16.

> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz,* 536 U.S. 622, 627 (2002)).[32]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[33]

Board's Analysis and Decision

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP group and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after these CIRP groups were established).

[32] *Id*. at 16-17.
[33] *Id*. at 19.

A. Board's Authority

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) 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.

The Board's analysis is detailed below.

B. Dismissal of Case Nos. 18-1036GC, 18-1516GC, and Case No. 20-1866 *as Prohibited Duplicate Appeals*

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation:

> 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*.[34]

Subsection (e)(1) requires that the group provider provide notice that the group is fully formed and complete.[35] Once the group is certified as complete, restrictions are placed on the ability for additional providers under common ownership:

> When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, ***no other*** *provider under common ownership or control may appeal to the Board the issue* that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.[36]

Pursuant to the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e), processing of an EJR on the Board's part dictates that the group is considered fully formed and, necessarily, that any

[34] 42 C.F.R. § 405.1837(b)(1) (emphasis added).
[35] 42 C.F.R. § 405.1837(e)(1).
[36] *Id*. (emphasis added).

additional providers outside of this group would be part of a duplicate case, violating those same CIRP regulations.[37] Similarly, Board Rule 4.6 prohibits duplicate filings.

The Board finds that the CY 2011 Part C days Methodist CIRP group under Case No. 18-1036GC is a duplicate case otherwise prohibited by 42 C.F.R. § 405.1837(b), (e)(1). There was another Methodist CY 2011 Part C days CIRP group under Case No. 15-0582GC entitled "Methodist Health System 2011 Post-Allina Decision Medicare Part C Days CIRP Group (Failure to Issue a Timely Determination)." In this earlier CIRP group, the Methodist Health System requested EJR over the Part C days issue for the same year and, on June 28, 2017, the Board granted that EJR request.

Similarly, the Board finds that the CY 2013 Part C days Allina CIRP group under Case No. 18-1516GC is a duplicate case otherwise prohibited by 42 C.F.R. § 405.1837(b), (e)(1). There was another Allina CY 2013 Part C days CIRP group under Case No. 16-0309GC entitled "Allina Health 2013 Post-Allina Decision Medicare Part C Days CIRP Group." In this earlier CIPR group, Allina requested EJR over the Part C days issue for the same year and, on January 12, 2018, the Board granted that EJR request.

Finally, the Board finds that the individual appeal for Methodist Dallas Medical Center (Prov. No. 45-0051; FYE 06/30/2014) in Case No. 20-1866 is a duplicate case otherwise prohibited by 42 C.F.R. § 405.1837(b), (e)(1). This provider is part of the Methodist Health System, as noted on its Letter of Representation, and was converted to an individual appeal when the group representative certified that Case No. 19-0151GC (Methodist Health System CY 2014 DSH Medicare Advantage Days CIRP Group) was complete, and the provider was the sole member of the group. However, the group representative failed to notify the Board that the appeal under Case No. 19-0151GC was duplicative of Case No. 16-1623GC (Methodist Health System 2014 Post-Allina Decision Medicare Part C Days CIRP Group), for which the Board granted EJR on September 7, 2017, over whether Part C days should be included in the numerator of the DSH fraction. Accordingly, to the extent Methodist Health System was not a participant in Case No. 16-1623GC, 42 C.F.R. 405.1837(e)(1) otherwise prohibits its appeal.

The Board notes that the EJR requests for which the Board granted EJR (as well as the Board's EJR decision itself) clearly encompassed the ***complete*** Part C DSH issue, *i.e.*, both the Medicare and Medicaid fractions. Per the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"),[38] the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction.[39] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the

[37] *See* 42 C.F.R. § 405.1837(e) ("[w]hen the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.").
[38] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[39] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.

Providers could bring suit in the D.C. Circuit.[40] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other. As the above mentioned cases were part of the same common ownership, for the same issue (Part C Days), and for the same fiscal years, any providers within the cases are in violation of 405.1837(b)(1) and (e) (as well as Board Rule 4.6), and thus must be dismissed.

C. Fiscal Years Under Appeal in Case No. 18-1406GC

One of the remaining cases in this EJR request is Case No. 18-1406GC and it appeals the fiscal period prior to 10/1/2013, and the period on or after that date –

18-1406GC *Henry Ford Health System 2013 DSH Medicare Advantage Days CIRP Group*

Although Case No. 18-1406GC was established as a CIRP group appeal, the CIRP group is fully formed but with only a single participant and, as a result, the Board is electing to now treat the case as an individual appeal because it meets the $10,000 amount-in-controversy requirement for an individual appeal and was timely filed. The appeal's issue statement challenges the pre-10/1/2013 Part C days issue, but also includes the following language challenging the 10/1/2013 and after Part C days rule:

> In 2013, while *Allina I* was pending in Federal Court, CMS amended is regulation again to exclude part C days from the numerator of the Medicaid fraction and count those days in the Medicare part A/SSI fraction. 78 Fed. Reg. 50,496, 50,614-20 (Aug. 19, 2013). The 2013 rule applies to discharges occurring on or after October 1, 2013.
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> The Provider also contends that CMS's 2013 rule is substantively invalid because it is inconsistent with the DSH statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), and is otherwise inconsistent with applicable law, arbitrary and capricious, and abuse of discretion, and unsupported by substantial evidence. *See* 42 C.F.R. § 412.106(a)(1)(ii). Further, the Provider contends that the rule is procedurally invalid under the applicable notice and comment rulemaking requirements prescribed by the Medicare statute, 42

[40] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

> U.S.C. § 1395hh, and the Administrative Procedure Act, 5 U.S.C. § 553.

In the EJR request, the Provider explains:

> The issue in these appeals concerns the appropriate treatment of Part C days in the DSH calculation for periods both before and after the October 1, 2013 rule change on this issue. For the reasons explained below, the Providers request EJR over only the portion of their appeals challenging the application of the agency's 2004 rule to their Medicare part A/SSI fractions and Medicaid discharges reflected in the Medicaid fraction prior to October 1, 2013, and not to the portion subject to the October 1, 2013, rule raising legal questions distinct from those raised for prior periods.[41]
>
> ***
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> The Providers also present different legal challenges to the MAC's application of the two different rules on Part C days to their DSH calculations. For the portion of their cost reporting periods covered by the 2004 rule, the Providers allege the MAC's treatment of Part C days in their DSH calculations violates the explicit terms of the *Allina* decisions and that the procedural issues identified by the Court in those cases have not be remedied. The Providers separately challenge CMS's 2013 rule as the product of legally invalid notice-and-comment rulemaking because, among other things, the agency neither acknowledged its change in position from the pre-2004 standard in the rule nor adequately addressed the financial impact of the change to DSH hospitals. These claims are the subject of court litigation separate from the *Allina* litigation in a case called *Florida Health. Fla. Health Scis. Ctr., Inc. v. Becerra*, No. CV 19-3487 (RC), 2021 WL 2823104 (D.D.C. July 7, 2021), appeal pending *sub nom. Allina Health Sys. et al. v. Becerra*, No 21-5192 (D.C. Cir. Sept. 9, 2021).[42]

Based on the appeal request for Case No. 18-1406GC, the Provider in Case No. 18-1406GC has appealed both the pre-10/1/2013 Part C days issue, as well as the 10/1/2013 and after Part C days issue. As such, the Board will bifurcate Case No. 18-1406GC to establish a new individual appeal for the period of 10/1/2013 – 12/31/2013 for the single participant, as it is a separate legal issue and thus is not subject to EJR or remand.

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[41] EJR Request at 3.
[42] *Id.* at 4.

Be advised that 42 C.F.R. § 405.1837(e) states that once a CIRP group is fully formed, as was the situation here, for Case No. 18-1406GC, no other commonly owned/controlled provider may pursue the CIRP group issue for that year without a Board order permitting that appeal: "For group appeals brought under paragraph (b)(1) of this section, once the group(s) is designated to be fully formed, absent an order from the Board modifying its determination, *no other provider under common ownership or control may appeal to the Board* ***the issue that is the subject of the group appeal*** with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal."[43]

D. Jurisdictional Requirements for Providers in Remaining Groups

The Board's analysis for the two remaining cases in this EJR request, Case Nos. 13-1937GC and 18-1406GC, 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. 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.[44, 45]

With respect to the "dissatisfaction" prong of the Board's jurisdiction regulation, for cost report periods ending prior to December 31, 2008, a provider 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*.[46] 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.[47]

On August 21, 2008, new regulations governing the Board were effective.[48] 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*

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[43] (Emphasis added.)
[44] 42 C.F.R. § 405.1835(a).
[45] 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).
[46] 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.).
[47] *Bethesda* at 1258-59.
[48] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

("*Banner*").[49] 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.[50]

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 ("CMS 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods that ended on or after December 31, 2008, and began before January 1, 2016, that were pending or filed on or after April 23, 2018.[51] Under this Ruling, if 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) is no longer applicable. However, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.[52]

The Providers included in the instant EJR request filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 6/30/2008 and 12/31/2013 and are governed by Bethesda and CMS Ruling CMS-1727-R.[53] The Board further finds that the Providers appeals are permitted under the dictates of *Bethesda* and CMS-1727-R because they self-disallowed their claims based on the regulation at issue and are challenging the validity of that regulation.

Finally, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000 as required for a group appeal for Case No. 13-1937GC.[54] As discussed above, the Board is electing to treat Case No. 18-1406GC as an individual appeal, and finds that it has met the $10,000 amount in controversy requirement for an individual appeal. The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for Case Nos. 13-1937GC and 18-1406GC and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount in each case.

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[49] 201 F. Supp. 3d 131 (D.D.C. 2016).
[50] *Banner* at 142.
[51] CMS Ruling CMS-1727-R at 1-2.
[52] *Id*. at unnumbered page 7.
[53] Under Ruling 1727-R, 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.
[54] *See* 42 C.F.R. § 405.1837.

E. Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[55] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[56] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates *before* October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[57] To date, CMS has yet to issue its new final rule.[58]

As the Providers' remaining appeals concern the FY 2008, and pre-10/1/2013 cost reporting periods, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued) for discharge dates *before* October 1, 2013. Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[59] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

F. Validity of CMS Ruling 1739-R

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction

[55] (Emphasis added.)
[56] CMS Ruling 1739-R at 1-2.
[57] Id. at 2.
[58] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[59] (Emphasis added.)

> conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[60]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[61] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[62]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [63] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[64]

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[60] EJR Request at 17.
[61] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).
[62] *See Southwest* at 6-7.
[63] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[64] *See* CMS 1739-R at 8.

As noted prior, the Board must grant EJR 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.[65] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

1) The Board hereby dismisses the 2013 Allina group (Case No. 18-1516GC), the 2011 Methodist group (Case No. 18-1036GC), and the Individual case (Case No. 20-1866), as they are duplicates that are in violation of the CIRP regulations at 405.1837(b)(1) and (e).

2) The Board bifurcates Case No. 18-1406GC to establish a new individual appeal for the period of 10/1/2013 – 12/31/2013 for the single participant.

3) The Board finds it has jurisdiction to hear the appeals of all providers in the remaining group appeals: Case Nos. 13-1937GC and 18-1406GC;

4) The Board hereby **denies** Providers' EJR Requests regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Providers will receive remand letters of this issue under separate cover; and

5) The Board hereby **grants** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeals.

[65] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

For the Board:

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA

10/27/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson Leong, FSS
Danelle Decker, National Government Services, Inc.
Bill Tisdale, Novitas Solutions, Inc.