



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: *Closure of Cases & Suspension of Jurisdictional & Substantive Claim Processes*
21-1491G King & Spalding CY 2016 DGME Fellow Penalty Present Year (II) Group
21-1492G King & Spalding CY 2016 DGME Fellow Penalty Prior and Penultimate Years (II) Group

Dear Messrs. Hettich and Leong:

As the parties are aware, King & Spalding, LLP (“King & Spalding”), the Providers’ designated representative, filed a consolidated request for expedited judicial review (“EJR”) on July 1, 2022 for the above-referenced optional group cases on the following issue:

[W]hether the formula for calculating the number of full-time equivalent (“FTE”) residents a hospital may count in a year for the purposes of direct graduate medical education [(“DGME”)] reimbursement, as contained in 42 C.F.R. [§] 413.79(c)(2)(iii), is unlawful because it penalizes hospitals that train “fellows” (*i.e.*, residents who are not in their initial residency period) while operating in excess of their FTE caps.¹

It has come to the Board’s attention that the Providers’ have filed a complaint in federal district court² to pursue the merits of their EJR request, notwithstanding the fact that the Board has not yet completed its jurisdictional review and not yet issued a determination on the EJR request. As set forth in more detail below, the Provider Reimbursement Review Board (“Board”) hereby takes the following actions consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure (“FRCP”) 62.1³:

1. Closes these 2 group cases; and
2. Suspends completion of its jurisdictional and substantive claim review processes.

¹ EJR Request at 1 (July 1, 2022). In addition, for one Provider that admittedly did not self-disallow this issue, that Provider seeks to have the self-disallowance regulation at 42 C.F.R. § 413.24(j) declared unlawful. *Id.* at 2.

² *The Univ. of Vermont Med. Ctr. Inc., et al. v. Becerra*, 1:22-cv-2252 (D.D.C. Aug. 1, 2022).

³ FRCP 62.1 is entitled “Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal.” While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance.

Procedural Background:

On July 1, 2022, King & Spalding initially filed an EJR request for Case Nos. 21-1491G and 21-1492G. Also, on July 1, 2022, King & Spalding filed a consolidated Request to Change Lead Medicare Administrative Contractor (“MAC”) in these two cases.⁴

On July 7, 2022, Federal Specialized Services (“FSS”) requested sixty (60) additional days to complete its jurisdictional review of the two cases. The Providers did not file any opposition to this request.

On July 8, 2022, the Board granted the request to change the MAC from National Government Services to WPS Government Health Administrators. By letter dated July 25, 2022, the Board granted an extension of time and issued a Scheduling Order that required the newly identified Medicare Contractor and/or FSS to respond to the EJR request on or before August 5, 2022, and the Providers to file their response to that filing on or before September 6, 2022. Further, *the Board’s letter found that the simultaneous filings of the EJR request and the change of MAC were **prejudicial*** to both the new lead Medicare Contractor and the Board in that the jurisdictional review and a finding of jurisdiction is a pre-requisite to the review of an EJR request. The Board also provided Notice of when the 30-day period for responding to the EJR request commenced, explaining that it would not commence until the Board completed its pre-requisite jurisdictional review of these optional groups, and that the Scheduling Order necessarily affected the 30-day period for the Board’s determination of authority required to decide the EJR request. The Board clarified that it would continue its review of the jurisdiction in these optional group cases, as well as review the Providers’ request for EJR, upon receipt of the requested information, or the September 6, 2022, filing deadline, whichever occurred first.

Through one letter for each case, dated August 3, 2022, the Medicare Contractor indicated that it was not aware of any jurisdictional impediments at that time, and had no objections to the Providers’ EJR requests.

On August 10, 2022, the Secretary published the Final Rule on Hospital Inpatient Prospective Payment Systems (“IPPS”) for Fiscal Year (“FY”) 2023 in the Federal Register.⁵ The IPPS Final Rule included a new payment formula for DGME costs that will be applied *retroactively*.⁶ Moreover, the Secretary modified the regulation at 42 C.F.R. § 413.79(c)(2)(iii) to state that, effective for cost reporting periods beginning on or after October 1, 2001, if the hospital’s unweighted number of FTE residents exceeds the limit described in the final rule, and the number of weighted FTE residents in accordance with § 413.79(b) also exceeds that limit, the respective primary care and obstetrics and gynecology weighted FTE counts and other weighted FTE counts are adjusted to make the total weighted FTE count equal the limit. If the number of FTE residents weighted in accordance with § 413.79(b) does not exceed that limit, then the allowable weighted FTE count is the actual weighted FTE count. Further, the Secretary made a conforming change to the regulations text at 42 C.F.R. § 413.79(d)(3) regarding application to the 3-year rolling average to state that for cost reporting periods beginning on or after October 1, 2001,

⁴ The EJR request would have been served on the MAC at the time of the filing of the EJR, which is the original MAC of record, not the MAC to which the provider was requesting the Board change the MAC to.

⁵ 87 Fed. Reg. 48780 (Aug. 10, 2022).

⁶ *Id.* at 49065-72.

the hospital's weighted FTE counts for the preceding two cost reporting periods are calculated in accordance with the payment formula at § 413.79(c)(2)(iii).

On August 29, 2022, the Board issued a Scheduling Order requiring additional briefing from the parties in the two cases. Specifically, the Board required the parties to supplement their filings related to the EJR request following the publication of the FY 2023 IPPS Final Rule. As a result of this subsequent legal development, the Board exercised its authority under 42 C.F.R. § 405.1842(e)(3) to require that the Group Representative provide a case-status update and confirm whether the EJR request has been rendered moot by the FY 2023 IPPS Final Rule or whether the participants in these groups remained committed to pursuing the EJR requests. If the participants remained committed to pursuing the EJR request, then they were to update the EJR request to (i) discuss the impact of the Final Rule on the EJR requests challenging the Secretary's policy and regulation establishing the payment methodology for determining payments to hospitals for the direct costs of approved DGME programs, specifically the method of calculating DGME payments to teaching hospitals when those hospitals' weighted FTE counts exceed their FTE cap; and, (ii) modify the EJR request, as relevant, based on this impact.

In addition, the Board's Scheduling Order referred to its earlier July 25, 2022 Notice of when the 30-day period to review an EJR request commences, and reaffirmed that this Notice remains in effect as the Board had not yet completed its jurisdictional review.

On September 19, 2022, King & Spalding responded and asserted that:

1. Their EJR request is not moot at the time because the Final Rule takes effect on October 1, 2022 and, as such, the Board continues to lack the authority to grant the relief requested for either of the two issues for which EJR was requested; and
2. Even after the 2023 Final Rule takes effect, the Board will continue to lack the authority to put aside CMS's self-disallowance regulations.

Further, King & Spalding informed the Board that, on August 1, 2022, the Providers filed a complaint in the U.S. District Court for the District of Columbia seeking judicial review of their appeals pursuant to 42 U.S.C. § 1395oo(f)(1), in order to preserve their right to interest under 42 U.S.C. § 1395oo(f)(2). King & Spalding gave the following explanation of why it filed the Complaint in the federal district court:

As noted above, in order to preserve their right to interest, the Providers filed a complaint on August 1, 2022, which was 31 days after they had filed their EJR request, with all required materials, with the Board. *See* 42 U.S.C. § 1395oo(f)(1) (allowing a provider to file a complaint if it has not received the Board's EJR decision "within thirty days after the Board receives" the "documents and materials as the Board shall require for purposes of rendering such determination"). **The Providers are aware that the Board is bound by CMS's regulation which interprets 42 U.S.C. § 1395oo(f)(1) to mean that**

the thirty-day clock does not begin to run until after the Board has determined that it has jurisdiction over the appeal and that there is no time limit for the Board to determine jurisdiction. *See* 42 C.F.R. § 405.1842(b)(2). We respectfully disagree with that interpretation of the statute for multiple reasons and have noted our disagreement in our complaint before the court. (Notably, while some other courts have upheld the agency’s regulation in this regard, it has not been addressed by the D.C. Circuit.)

The Group Representative asserts that further proceedings in these cases should be stayed pending the resolution of that complaint, citing 42 C.F.R. § 405.1842(h)(3)(iii) and 73 Fed. Reg. 30,189, 30.214-15 (May 23, 2008).

Two days later, on September 21, 2022, the Providers filed their Preliminary Position Paper (“PPP”). Notwithstanding the Board’s August 29, 2022 order directing the Providers to address the impact of the changes in the FY 2023 IPPS Final Rule on their EJR request, the Providers’ PPP does ***not*** address the Secretary’s modification of the regulatory provision that the Providers are challenging and the new payment formula for DGME costs that will be applied *retroactively*.

On September 28, 2022, the Medicare Contractor filed a Motion to dismiss these cases pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), which bars the Board from conducting any further proceedings once the provider commences action in Federal Court.

The Providers had 30 days to respond to the Motion per Board Rule 44.3. The Providers filed their response on the 30th day, *i.e.*, October 28, 2022, and asserted that the Board should deny the Medicare Contractor’s request because CMS regulations bar any further Board proceedings in an appeal once a provider has filed suit in Federal court seeking relief for said appeal. The Providers request that the Board stay these appeals, pending the outcome of the Federal court litigation.

King and Spalding ***filed a Complaint in the U.S. District Court for the District of Columbia regarding the merits of their EJR request as filed in these appeals***, on August 1, 2022,⁷ which is of critical significance because 42 C.F.R. § 405.1842(h)(3) directs the Board to conduct no further proceedings under such circumstances:

(h) *Effect of final EJR decisions and lawsuits on further Board proceedings –*

(3) *Provider lawsuits.* (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not

⁷ *See supra* note 2 (A copy of the Complaint is attached to the Providers’ Response to Scheduling Order filed on Sept. 19, 2022).

within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.

*(iii) If the lawsuit is filed before a final EJR decision is issued on the legal question, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved.*⁸

Accordingly, the filing of the Complaint in Federal District Court made clear that the Providers had abandoned the Board's jurisdictional and substantive claim review processes. In the Complaint, the Group Representative states that the Board did not rule on the request for EJR in these appeals within the required 30-day timeframe, as required by the Medicare Act, citing 42 U.S.C. § 1395oo(f)(1), and thus the Plaintiffs in these groups have 60 days in which to file a civil action challenging the Board's lack of decision.⁹

Board Findings and Ruling:

The Board must decide what effect the Providers' filing of a lawsuit has on the proceedings before the Board in connection with the above-referenced group cases.

A. The 30-day Period For Responding to the EJR Requests Has Not Yet Begun and Bypassing the Completion of that Process Automatically Raises Potential Fraud, Waste and Abuse Concerns.

As discussed in more detail above, the Board's correspondence in these cases has notified the parties on multiple occasions, in detail, that the 30-day period for EJR review does not begin until the Board completes its jurisdictional review and finds jurisdiction. Set forth below is a summary of that explanation.

Parties to a Board appeal may request EJR pursuant to the provisions of 42 U.S.C. § 1395oo(f)(1) which states, in relevant part:

Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such

⁸ (Emphasis added.)

⁹ Complaint, ¶ 47.

provider *may file* a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days **after the Board receives the request and such accompanying documents and materials**, and the determination shall be considered a final decision and not subject to review by the Secretary.*¹⁰

To implement this statutory provision, the Secretary promulgated the regulation at 42 C.F.R. § 405.1842, setting forth the process for obtaining EJR, and the Board's obligations under the statute. As demonstrated by the following excerpts, 42 C.F.R. § 405.1842 makes clear that the 30-day period for processing an EJR request does not begin until *after* the Board rules on jurisdiction:

(a) *Basis and scope.* (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter** (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).

(2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).

(4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act *only if*—

(i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue** and a determination by the Board that it has no authority to decide the relevant legal question; or

(ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days after finding jurisdiction**

¹⁰ (Emphasis added).

over the matter at issue and notifying the provider that the provider's EJR request is complete.

(b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question.**

(2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal Under paragraphs (d) and (e) of this section, **a provider may request a determination of the Board's authority to decide a legal question, but the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act [i.e., 42 U.S.C. § 1395oo(f)(1)] does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete.**¹¹

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period “does not begin to run *until the Board finds jurisdiction* to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider’s request is complete.”¹² Moreover, the Board is bound by this regulation because, as stated in 42 C.F.R. § 405.1867, “[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act *and regulations issued thereunder*” Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days *after* it determines whether it has jurisdiction and the

¹¹ (Emphasis added).

¹² 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: “In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(1), ***we would emphasize that a Board finding that it has jurisdiction over the specific matter at issue is a prerequisite for its determination of its authority to decide the legal question,*** and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR ‘[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].’ In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision, that the 30-day time limit specified in section 1878(f)(1) of the Act for the Board to act on a provider's complete request does not begin to run until the Board has found jurisdiction*** on the specific matter at issue.” (emphasis added)).

request for EJR is complete. See 42 C.F.R. § 405.1842.¹³

Thus, it is clear that the 30-day clock does not start until *after* the Board determines it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request.¹⁴

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR “*if [it] may obtain a hearing under subsection (a). . .*”¹⁵ Thus, as the Court in *Alexandria Hospital v. Bowen* (“*Alexandria*”)¹⁶ noted, “the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals.”¹⁷ The Court in *Alexandria* continued, stating:

Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal.* The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction.* EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .

The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the*

¹³ (Emphasis added.)

¹⁴ Note that the Board's use of the term “stay” (as used in this and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

¹⁵ 42 U.S.C. § 1395oo(f)(1) (emphasis added).

¹⁶ *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986) (hereinafter “*Alexandria*”).

¹⁷ *Alexandria* at 1244. See H.R. Rep. No. 96-1167, reprinted in 1980 U.S. Code Cong. & Ad. News at 5757; See also *San Francisco Gen. Hosp. v. Shalala*, No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan*, 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen*, Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).

*hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is **without merit**.*¹⁸

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, would still be able to prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.¹⁹ Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

The above discussion makes it clear that, per the regulations at 42 C.F.R. §§ 405.1837(a)(4)(ii) and 405.1837(b)(2), the 30-day EJR review period, specified at 42 U.S.C. § 1395oo(f)(1), does not begin until the Board completes its jurisdictional review process and finds jurisdiction.

B. Status of the Cases and the Board's Jurisdictional Review

King and Spalding filed its lawsuit in federal district court on August 1, 2022 – before the Board had completed its jurisdictional review to confirm whether it had jurisdiction to hear all of the disputes raised in the providers' EJR request *and* whether the record was sufficiently developed following the August 10, 2022 Final Rule. Having sufficient time to complete the jurisdictional and substantive claim review²⁰ process is important to ensure that the groups, and all the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules. Without a proper jurisdictional review, fraud, waste and abuse concerns could arise. Specifically, absent a proper jurisdictional review, there is a risk of prohibited participation of CIRP providers in optional groups.

As stated above, 42 C.F.R. § 405.1842(h)(3)(iii) specifies that, “[i]f the lawsuit is filed before a final EJR decision is issued on the legal question, *the Board may **not** conduct any further proceedings* on the legal question or the matter at issue until the lawsuit is resolved.”²¹

King and Spalding has made clear in its filings before the Board and in Court that it disagrees with the Board's interpretation of the jurisdictional requirements required in EJR proceedings and the need to resolve any jurisdictional and substantive challenges before ruling on an EJR request. For the cases in which the Board has not yet issued an EJR determination, its lawsuit is based on a

¹⁸ *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

¹⁹ It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules.

²⁰ As stated in Board Rule 44.5, “[t]he Board adoption 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.”

²¹ (Emphasis added.)

contention that the Board failed to process its EJR request in the 30-day period prescribed in 42 U.S.C. § 1395oo(f)(1).

Significantly, the Board consistently notified the parties that the 30-day period had not begun because the Board had not completed its jurisdictional and substantive claim review. *However, at no point in the proceedings before the Board has King and Spalding referenced or challenged the Board's stated reliance on 42 C.F.R. § 405.1842(b)(2) in issuing that notification or otherwise challenged the validity of that regulation until after it filed its Complaint in federal district court.* In this regard, the Board notes that King & Spalding *neither* filed opposition to FSS' request for an extension on the time to respond to the EJR request *nor* filed objections to the Board's July 8, 2022 Scheduling Order granting that extension. As a result, it is clear that, through the filing of that litigation, King and Spalding has abandoned the Board's jurisdictional review process and appears to be challenging the Secretary's implementation at 42 C.F.R. §§ 405.1842(a)(4)(ii) and 405.1842(b)(2) of 30-day period prescribed in § 1395oo(f)(1) and the Board's notice to the parties of its reliance on those regulations.

Moreover, the record is clear that King and Spalding filed a lawsuit in federal district court on August 1, 2022, ***without notifying the Board or the opposing party***, of its intent to file the Complaint or the initiation of federal litigation. The Board finds that King & Spalding's decision to delay notice to the Board and the opposing parties of its filing of the litigation is tantamount to bad faith and actively created the confusion surrounding the status of these cases at the Board because it ignored the Board's July 8, 2022 notice to the parties that, pursuant to 42 C.F.R. § 405.1842 and 42 U.S.C. § 1395oo(f)(1), the 30-day period for the Board to review an EJR request had not yet begun. Indeed, King & Spalding's action, taken without notice to the Board or the opposing parties, demonstrate that it had no intention of exhausting its administrative remedies before the Board. Pursuant to Board Rule 1.3 (Nov. 1, 2022),²² King & Spalding had a duty to communicate early and in good faith with the Board and the opposing parties (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

1.3 Good Faith Expectations

In accordance with the regulations, the Board expects the parties to an appeal to communicate early, act in good faith, and attempt to negotiate a resolution to areas of misunderstanding and differences. The duty to communicate early and act in good faith applies to dealings with the opposing party, the Board, and/or any relevant nonparty.

Similarly, pursuant to Board Rule 5.2 (Nov. 1, 2021), King & Spalding, as the Providers' designated representative, is responsible for being familiar with, and following, Board rules and procedures and

²² The recent changes to the Rules (effective Nov. 1, 2021) were first published in June 16, 2021 and, in advance of their effective date, invited comments from all interested individuals, providers, government contractors and other organization to be submitted by July 30, 2021. Subsequently on September 30, 2021, based on its review of that feedback, the Board then published further revisions to the Rules (effective Nov. 1, 2021). *See* Board Order No. 1 (available at: <https://www.cms.gov/files/document/revised-prrb-rules-v-30-cover-order-1-superseded-v-31.pdf>); Board Alerts 21 and 22 (available at <https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts>); Board Order No. 2 (<https://www.cms.gov/files/document/current-prrb-rules-v-31-cover-order-2-november-1-2021.pdf>).

governing regulations (including 42 C.F.R. § 405.1842(b)(2)), and timely responding to correspondence or requests from the Board or the opposing party:

5.2 Responsibilities

The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:

- The Board’s governing statute at 42 U.S.C. § 1395oo;
- *The Board’s governing regulations at 42 C.F.R. Part 405, Subpart R;* and
- *These Rules*, which include any relevant Orders posted at <https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions> (see Rule 1.1).

Further, *the case representative is responsible for:*

- Ensuring his or her contact information is current with the Board, including a current email address and phone number;
- Meeting the Board’s deadlines; and
- *Responding timely to correspondence or requests from the Board or the opposing party.*

Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.²³

These circumstances make clear that King & Spalding had a duty, pursuant to Board Rule 1.3, “to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty.” King & Spalding’s failure to comply with Board Rule 1.3, through prompt notification of the lawsuit on, or about, August 1, 2022 prejudiced the Board, FSS and the Medicare Contractors. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay or cease work on these group cases and the underlying participants in favor of other time-sensitive work. Finally, the Board’s August 29, 2022 Scheduling Order requiring additional briefing from the parties in the two cases was clearly warranted under 42 C.F.R. § 405.1842(e)(3) given the fact that the FY 2023 IPPS Final Rule appears to grant most, if not all, the relief the Providers are seeking.

²³ (Italics emphasis added.) *See also Baptist Mem’l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) (Circuit Court affirming the District Court’s grant of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating: “The court therefore granted summary judgment to the Board. Because the Board’s procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm.”).

The Board admonishes King and Spalding for blatantly ignoring Board Rule 1.3 through its failure to timely communicate with the Board and the opposing party of the litigation it filed and its intention to abandon the Board's ongoing proceedings, which included:

1. The Board's ongoing jurisdiction and substantive claim review processes.
2. The development of the record in the two cases following the publication of the August 10, 2022 Final Rule, which modified the regulation at issue and will apply retroactively.

The regulation at 42 C.F.R. § 405.1842(h)(iii) bars the Board from conducting any further proceedings. The Providers are pursuing the merits of their appealed issue(s) in the District Court for the District of Columbia, and there are no remaining issues beyond the EJR request.²⁴ Accordingly, consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure 62.1²⁵ the Board takes the following actions:

1. Closes these 2 group cases and removes them from the Board's docket; and
2. Suspends completion of its jurisdictional and substantive claim review processes; and
3. Defers consideration of any potential remedial action based on King & Spalding's violations of the Board Rules and its governing regulations until there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.

Accordingly, the Board hereby closes these cases and removes them from the Board's docket. The Board will conduct no further proceedings in these appeals absent a remand from the Administrator, pursuant to 42 C.F.R. 405.1877(g)(2).

Board Members Participating:

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

For the Board:

11/1/2022

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Jacqueline Vaughn, OAA

²⁴ The Board notes that, *in order for the Board to have jurisdiction over a group*, the group may only contain one legal issue per 42 C.F.R. § 405.1837(a) and, as such, there should be no other issues outside of the EJR request which, in turn, should also contain only one legal issue per the same authority.

²⁵ See *supra* note 3.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Board Decision***
The Heart Hospital Baylor Plano (67-0025)
FYE 12/31/2014
Case No. 16-1900

Dear Mr. Ravindran,

The Provider Reimbursement Review Board (“Board”) has reviewed the documents in the above referenced appeal and dismisses the DSH/SSI – Provider Specific issue. The decision of the Board is set forth below.

Pertinent Facts:

On June 20, 2016, the Board received Provider’s Individual Appeal Request appealing the Medicare Contractor’s failure to issue a timely Notice of Program Reimbursement (“NPR”) for fiscal year ending December 31, 2014. The initial appeal contained the eight (8) following issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI (Systemic Errors)
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days
5. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days
6. DSH Payment – SSI Fraction/Dual Eligible Days
7. DSH Payment – Medicaid Fraction/Dual Eligible Days
8. 2 Midnight Census IPPS Payment Reduction

On August 11, 2016, Issue 8 was transferred to a group appeal. On February 27, 2017, Issues, 2, 4, 5, 6, and 7 were also transferred to group appeals. The two remaining issues are Issue 1- DSH/SSI Percentage (Provider Specific) and Issue 3 – DSH – Medicaid Eligible Days.

The Provider summarizes its DSH/SSI – Provider Specific issue as follows:

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Case No. 16-1900

The Heart Hospital Baylor Plano (67-0025)

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The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.

The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

The Provider contends that the SSI percentage issued by CMS is flawed.

The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).¹

The Provider described its DSH/SSI (Systemic Errors) issue, which has been transferred to Case Number 17-0806GC, as follows:

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

The Providers [sic] challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA Records
2. Paid days vs. Eligible Days
3. Not in agreement with provider's records
4. Fundamental problems in the SSI percentage calculation

¹ Individual Appeal Request, Issue 1.

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Case No. 16-1900

The Heart Hospital Baylor Plano (67-0025)

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5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.²

The Medicare Contractor filed a Jurisdictional Challenge on May 8, 2018, arguing the DSH Provider Specific and DSH Systemic Errors issues are identical and that, as a result, one should be dismissed. The Provider filed a response on June 11, 2018, arguing that these two issues represent different components of the SSI issue. It contends that the Systemic Errors issue involves inaccurate MedPAR data, specifically several categories of days being omitted from the SSI percentage. It claims that the Provider Specific issue “is not addressing the errors which result from CMS’ improper data matching process but is addressing the various errors of omission and commission that do not fit into the “systemic errors” category, but specifically argues that “the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio.”

Board Decision:

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

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue from this appeal. This analysis of Issue 1 has two components:

1. The Provider’s disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and
2. The Provider’s request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

A. First Aspect of Issue 1

The Board finds that the first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI (Systemic Errors) issue that was transferred to Group Case No. 17-0806GC.

The first aspect of Issue 1 in the present appeal concerns “whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation.”³ The Provider’s legal basis for this aspect of Issue 1 is simply that the Medicare Contractor “did not determine

² *Id.* at Issue 2.

³ Individual Appeal Request, Issue 1.

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The Heart Hospital Baylor Plano (67-0025)

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Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i).⁴ Similarly, the Provider argues that “it[s] SSI percentage published by [CMS] was incorrectly computed . . .” and it “. . . [s]pecifically . . . disagrees with the MAC’s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary’s Regulations.”⁵ Issue 2, transferred to group Case No. 17-0806GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not “specific” to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 17-0806GC. Further, any alleged “systemic” issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.⁶ The Provider’s reliance upon referring to Issue 1 as “Provider Specific” and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged “provider specific” errors can be distinguished from the alleged “systemic” issue rather than being subsumed into the “systemic” issue appealed in Case No. 17-0806GC.

Accordingly, the Board must find that Issue 1 and Issue 2, which was transferred to Group Case No. 17-0806GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

B. Second Aspect of Issue 1

The Board finds that the second aspect of the DSH SSI (Provider Specific) issue involves the Provider’s request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider’s DSH percentage, “[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request” The Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. Accordingly, the second aspect of Issue 1 is dismissed from the appeal.

⁴ *Id.*

⁵ *Id.*

⁶ The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. See *Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

Board Decision

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The Heart Hospital Baylor Plano (67-0025)

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Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety, from this appeal. Since the Medicaid Eligible Days issue is still active in the appeal, Case No. 16-1900 will remain open.

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

Board Members Participating:

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Robert A. Evarts, Esq.
Kevin D. Smith, CPA
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For the Board:

11/7/2022

X Kevin D. Smith, CPA

Kevin D. Smtih, CPA

Board Member

Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Bill Tisdale, Novitas Solutions, Inc. (J-H)



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Via Electronic Delivery

Anita Hossfeld
Transitions Hospice Care of Georgia, Inc.
1202 N. Tennessee St., Ste. 101
Cartersville, GA 30120

RE: *Notice of Dismissal*
Transitions Hospice Care of Georgia, Inc. (Prov. No. 11-1641)
FYE 10/31/2013
Case No. 15-0769

Dear Ms. Hossfeld:

On October 31, 2022, The Provider Reimbursement Review Board (“Board” or “PRRB”) issued a Request for Status of Appeal to the Provider ordering that the Provider’s Representative respond within fifteen (15) days whether the Provider is still pursuing this appeal. The order specifically stated it was exempt from the Alert 19 suspension of Board-set deadlines and that “[f]ailure to submit a timely response to this request will result in dismissal of the case.” As of the date of this letter, no response has been submitted by the Provider’s Representative.

Previously, the Board had issued two Notices of Hearing in 2021 which passed with no activity on the Provider’s part. The Board notes that there has been no activity on the Provider’s part since the Provider filed its Preliminary Position Paper on August 21, 2015.

Pursuant to 42 C.F.R. § 405.1868:

(b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—

- (1) Dismiss the appeal with prejudice;
- (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
- (3) Take any other remedial action it considers appropriate.¹

Having issued an Order for the Provider’s Representative to give a case status update and advise whether the Provider is still pursuing the appeal and receiving no response and having exempted that Order from Board Alert 19, the Board hereby deems the appeal abandoned given that the

¹ See also Board Rules 4.1 & 41.2

Provider again failed to respond (whether timely or not), the Provider has not responded to the 2 separate Notices of Hearing, and the Provider has been inactive in this case since 2015. Accordingly, the Board dismisses this case pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b) and removes it from the Board's docket.

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

Board Members:

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For the Board:

11/15/2022

 Clayton J. Nix

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Chair
Signed by: PIV

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
Sanford Health CY 2016 Capital DSH CIRP Group
Case No. 20-0717GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (“Board”) has reviewed the Provider’s October 17, 2022 request for expedited judicial review (“EJR”) in the above-referenced common issue related party (“CIRP”) group appeal.¹ The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Providers are

[C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)², which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1886(d)].”³

Background

Under the inpatient prospective payment system (“IPPS”), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for

¹ Sanford Health is a health system with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 20-0717GC for the year 2016. As Sanford Health designated the CIRP group fully formed, the health system is prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): “When the Board has determined that a group appeal brought under paragraph (b)(1) . . . 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.”

² Codified at 42 U.S.C. § 1395ww(d)(8)(E).

³ Request for Expedited Judicial Review at 3 (Oct. 17, 2022) (“EJR Request”). See also Issue Statement – Capital DSH.

operating costs (“operating IPPS”) as set forth at § 1395ww(d); and one for capital costs (“capital IPPS”) as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.⁴ This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board (“MGCRB”) which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area⁵ for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.⁶ This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.⁷ Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁸

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.⁹ One of the adjustments is the hospital-specific Disproportionate Share Hospital (“DSH”) adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.¹⁰

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage (“DPP”).¹¹ As a proxy for utilization by low-income

⁴ Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), available at <https://oig.hhs.gov/oas/reports/region1/11700500.pdf> (last visited Oct. 20, 2022) (“*Significant Vulnerabilities*”).

⁵ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html> (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (“CBSAs”) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).

⁶ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). See also *Significant Vulnerabilities* at 4-5.

⁷ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁸ *Id.*

⁹ See 42 U.S.C. § 1395ww(d)(5).

¹⁰ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

¹¹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.¹²

The DSH adjustment provided under operating IPPS is *not* at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.¹³ OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall*, for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .

(B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;*

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

¹² See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

¹³ Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

(C) In this paragraph, the term “capital-related costs” has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.¹⁴

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary “may provide for an adjustment to account variations in relative costs.” As described below, the Secretary exercised his discretion to establish the *capital* DSH adjustment at issue in this case which is limited in that it **only** applies to *urban* hospitals with 100 or more beds and that serve low income patients.¹⁵

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.¹⁶ In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process), we have the latitude to develop adjustments based on combined costs for the capital prospective payment system.*

We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should

¹⁴ (Underline and italics emphasis added.)

¹⁵ 42 C.F.R. § 412.320(a)(1). See also MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).

¹⁶ 56 Fed. Reg. 43356 (Aug. 30, 1991).

reflect only the higher Medicare costs associated with teaching activity and treating low income patients.¹⁷

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $(\{1 + \text{DSHP}\}^{0.4176} - 1)$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.

Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.¹⁸

In adopting his proposal, the Secretary gave the following justification:

Comment: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.

Response: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also

¹⁷ *Id.* at 43369-70 (emphasis added).

¹⁸ *Id.* at 43377.

be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries.**¹⁹

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(1){ii} of the regulations.²⁰

¹⁹ *Id.* at 43409-10 (bold and underline emphasis added).

²⁰ *Id.*

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as “[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high ‘total government’ usage”:

In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.²¹

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.²²

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare’s payment to recognize these higher Medicare patient care costs.²³

²¹ *Id.* at 43378.

²² *Id.* at 43379.

²³ (Emphasis added.)

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

Comment: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

Response: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will **not** be eligible for capital disproportionate share payments.²⁴

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital’s disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.²⁵

²⁴ (Bold and underline emphasis added.)

²⁵ *Id.* at 43452-53.

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (“BBRA”) and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.²⁶ IPPS hospitals are reclassified per BBRA § 401 are often referred to as “§ 401 hospitals.”

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for **all** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

*A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for **all** purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and **disproportionate share calculations** (§ 412.106) as of the effective date of the reclassification.*²⁷

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes.*** In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific

²⁶ BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

²⁷ 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113.* In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106–113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

*We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. **Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify.** As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.²⁸*

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and

²⁸ 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

Services Administration which is available via the ORHP website at <http://www.nal.usda.gov/orph> or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.²⁹

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase “the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area”, it would appear that hospitals reclassified from urban to rural were *not* eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b) through (g)** of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.**³⁰

²⁹ *Id.* at 47048.

³⁰ (Bold and underline emphasis added.)

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. *Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS*

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.³¹ Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas (“CBSAs”) and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.³² On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas (“MSAs”) and the new Micropolitan Areas based on Census 2000 data.³³

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB’s new CBSA designations.³⁴ With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

³¹ Pub. L. 108–173

³² 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

³³ *Id.*

³⁴ 69 Fed. Reg. 48916 (Aug. 11, 2004).

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result

of redesignation of an MSA by the Executive Office of Management and Budget.³⁵

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: “A hospital is classified as a ‘disproportionate share hospital’ for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area.”³⁶ As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital’s location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.³⁷

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB’s new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for

³⁵ *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

³⁶ (Emphasis added.)

³⁷ 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.

As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.³⁸

³⁸ 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary³⁹ announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.⁴⁰

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OMB's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.⁴¹

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital

³⁹ of the Department of Health and Human Services.

⁴⁰ 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

⁴¹ *Id.*

reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.⁴²

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.⁴³

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.⁴⁴

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* (“*Toledo*”),⁴⁵ wherein the hospital made the following contentions:

⁴² *Id.*

⁴³ *Id.*

⁴⁴ (Bold emphasis added.)

⁴⁵ 2021 WL 4502052 (D.D.C. 2021).

Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to “take into account” relative costs of capital for various hospital types and areas of location, as subsection (g) requires.⁴⁶

In *Toledo*, U.S. District Court for the District of Columbia (“D.C. District Court”) outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.⁴⁷ The Court also noted how Congress enacted legislation in 1999⁴⁸ allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.⁴⁹ The Court also noted the separate IPPS payment for a hospital’s *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).⁵⁰ The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.⁵¹

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants’ Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.⁵²

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.⁵³ The Court next examined, however, whether the Secretary’s decision to do so was reasonable. The D.C. District Court made the following findings:

⁴⁶ *Id.* at *8 (citations omitted).

⁴⁷ *Id.* at *2.

⁴⁸ 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a “§ 401” hospital.

⁴⁹ *Toledo* at *3.

⁵⁰ *Id.* at *3-4.

⁵¹ *Id.* at *4.

⁵² *Id.* at *5.

⁵³ *Id.* at *6-8.

1. “if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it.”⁵⁴
2. The Secretary’s decision to not provide a capital DSH adjustment was arbitrary because:
 - “The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006.”⁵⁵
 - “[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements.”⁵⁶
 - “The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp.*, 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why ‘added precision’ ‘would not justify the added complication’) (quotation omitted).”⁵⁷
 - “The agency cannot ‘entirely fail[] to consider’ the “relevant data” and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all.”⁵⁸

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because “vacatur of a rule is not an appropriate remedy on review of an adjudication.”⁵⁹ Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants’ eligibility for a capital DSH adjustment.⁶⁰

Providers’ Request for EJR

The Providers state that EJR is appropriate because the they are challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).⁶¹

The Providers are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent

⁵⁴ *Id.* at *11.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at *11-12.

⁵⁹ *Id.* at *12.

⁶⁰ *Id.*

⁶¹ Request for EJR at 2.

with 42 U.S.C. § 1395ww(d)(8)(E) which states that hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1395ww(d)].” The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(E) and 1395ww(g), and the regulation must be found invalid.⁶² Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.

Since the Board is bound by the regulations being challenged,⁶³ namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers’ Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.

Board Decision

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

A. Jurisdiction

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 it as a “self-disallowed cost,” pursuant to the Supreme Court’s reasoning set out in *Bethesda Hospital Association v. Bowen* (“*Bethesda*”).⁶⁴ 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.⁶⁵

On August 21, 2008, new regulations governing the Board were effective.⁶⁶ 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-

⁶² *Id.* at 3.

⁶³ See 42 C.F.R. § 405.1867.

⁶⁴ 108 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.).

⁶⁵ *Bethesda*, 108 S. Ct. at 1258-59.

⁶⁶ 73 Fed. Reg. 30190, 30240 (May 23, 2008).

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*”).⁶⁷ 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.⁶⁸

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

The Board has determined that the challenge involving the capital DSH payment in this case is governed by CMS Ruling CMS-1727-R and that the Board has jurisdiction pursuant to that Ruling since the Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii) for fiscal years ending prior to December 31, 2016. Both Providers have appealed from original NPRs. The Board also finds that both participants in this CIRP group filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. The amount in controversy also meets the \$50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

Finally, the Board notes that the Medicare Contractor filed jurisdictional review documents on two separate occasions noting there are no jurisdictional issues in the case.

B. Board’s Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in this group appeal are entitled to a hearing before the Board;
- 2) Based upon the participants’ assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

⁶⁷ 201 F. Supp. 3d 131 (D.D.C. 2016).

⁶⁸ *Id.* at 142.

- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(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. Since this is the only issue under dispute in this case, 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
Ratina Kelly, CPA

FOR THE BOARD:

11/15/2022

 Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: John Bloom, Noridian Healthcare Solutions (J-F)
Wilson Leong, FSS



DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: *Expedited Judicial Review Determination*
Univ of Rochester CY 2016 Capital DSH CIRP Group
Case No. 20-1282GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (“Board”) has reviewed the Provider’s October 17, 2022 request for expedited judicial review (“EJR”) in the above-referenced common issue related party (“CIRP”) group appeal.¹ The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Providers are

[C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)², which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1886(d)].”³

Background

Under the inpatient prospective payment system (“IPPS”), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for

¹ The University of Rochester Medical Center is a health system with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 20-1282GC for the year 2016. As the University of Rochester Medical Center designated the CIRP group fully formed, the health system is prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): “When the Board has determined that a group appeal brought under paragraph (b)(1) . . . 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.”

² Codified at 42 U.S.C. § 1395ww(d)(8)(E).

³ Request for Expedited Judicial Review at 3 (Oct. 17, 2022) (“EJR Request”). *See also* Issue Statement – Capital DSH.

operating costs (“operating IPPS”) as set forth at § 1395ww(d); and one for capital costs (“capital IPPS”) as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.⁴ This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board (“MGCRB”) which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area⁵ for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.⁶ This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.⁷ Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁸

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.⁹ One of the adjustments is the hospital-specific Disproportionate Share Hospital (“DSH”) adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.¹⁰

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage (“DPP”).¹¹ As a proxy for utilization by low-income

⁴ Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), available at <https://oig.hhs.gov/oas/reports/region1/11700500.pdf> (last visited Oct. 20, 2022) (“*Significant Vulnerabilities*”).

⁵ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html> (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (“CBSAs”) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).

⁶ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). See also *Significant Vulnerabilities* at 4-5.

⁷ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁸ *Id.*

⁹ See 42 U.S.C. § 1395ww(d)(5).

¹⁰ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

¹¹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.¹²

The DSH adjustment provided under operating IPPS is *not* at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.¹³ OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall*, for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .

(B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;*

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

¹² See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

¹³ Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

(C) In this paragraph, the term “capital-related costs” has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.¹⁴

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary “may provide for an adjustment to account variations in relative costs.” As described below, the Secretary exercised his discretion to establish the *capital* DSH adjustment at issue in this case which is limited in that it **only** applies to *urban* hospitals with 100 or more beds and that serve low income patients.¹⁵

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.¹⁶ In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process), we have the latitude to develop adjustments based on combined costs for the capital prospective payment system.*

We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should

¹⁴ (Underline and italics emphasis added.)

¹⁵ 42 C.F.R. § 412.320(a)(1). See also MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).

¹⁶ 56 Fed. Reg. 43356 (Aug. 30, 1991).

reflect only the higher Medicare costs associated with teaching activity and treating low income patients.¹⁷

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $(\{1 + \text{DSHP}\}^{0.4176} - 1)$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.

Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.¹⁸

In adopting his proposal, the Secretary gave the following justification:

Comment: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.

Response: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also

¹⁷ *Id.* at 43369-70 (emphasis added).

¹⁸ *Id.* at 43377.

be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries.**¹⁹

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(1){ii} of the regulations.²⁰

¹⁹ *Id.* at 43409-10 (bold and underline emphasis added).

²⁰ *Id.*

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as “[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high ‘total government’ usage”:

In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.²¹

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.²²

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare’s payment to recognize these higher Medicare patient care costs.²³

²¹ *Id.* at 43378.

²² *Id.* at 43379.

²³ (Emphasis added.)

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

Comment: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

Response: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will **not** be eligible for capital disproportionate share payments.²⁴

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital’s disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.²⁵

²⁴ (Bold and underline emphasis added.)

²⁵ *Id.* at 43452-53.

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (“BBRA”) and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.²⁶ IPPS hospitals are reclassified per BBRA § 401 are often referred to as “§ 401 hospitals.”

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for **all** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

*A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for **all** purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and **disproportionate share calculations** (§ 412.106) as of the effective date of the reclassification.*²⁷

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes.*** In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific

²⁶ BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

²⁷ 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113.* In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106–113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

*We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. **Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify.** As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.²⁸*

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and

²⁸ 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

Services Administration which is available via the ORHP website at [http:// www.nal.usda.gov/orph](http://www.nal.usda.gov/orph) or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.²⁹

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase “the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area”, it would appear that hospitals reclassified from urban to rural were *not* eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b) through (g)** of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.**³⁰

²⁹ *Id.* at 47048.

³⁰ (Bold and underline emphasis added.)

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. *Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS*

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.³¹ Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas (“CBSAs”) and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.³² On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas (“MSAs”) and the new Micropolitan Areas based on Census 2000 data.³³

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB’s new CBSA designations.³⁴ With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

³¹ Pub. L. 108–173

³² 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

³³ *Id.*

³⁴ 69 Fed. Reg. 48916 (Aug. 11, 2004).

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result

of redesignation of an MSA by the Executive Office of Management and Budget.³⁵

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: “A hospital is classified as a ‘disproportionate share hospital’ for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area.”³⁶ As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital’s location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.³⁷

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB’s new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for

³⁵ *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

³⁶ (Emphasis added.)

³⁷ 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.

As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.³⁸

³⁸ 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).

4. *August 18, 2006 Revisions to the Capital DSH Adjustment*

In the FY 2007 Proposed IPPS Rule, the Secretary³⁹ announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.⁴⁰

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OMB's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.⁴¹

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital

³⁹ of the Department of Health and Human Services.

⁴⁰ 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

⁴¹ *Id.*

reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.⁴²

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.⁴³

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.⁴⁴

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* (“*Toledo*”),⁴⁵ wherein the hospital made the following contentions:

⁴² *Id.*

⁴³ *Id.*

⁴⁴ (Bold emphasis added.)

⁴⁵ 2021 WL 4502052 (D.D.C. 2021).

Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to “take into account” relative costs of capital for various hospital types and areas of location, as subsection (g) requires.⁴⁶

In *Toledo*, U.S. District Court for the District of Columbia (“D.C. District Court”) outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.⁴⁷ The Court also noted how Congress enacted legislation in 1999⁴⁸ allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.⁴⁹ The Court also noted the separate IPPS payment for a hospital’s *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).⁵⁰ The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.⁵¹

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants’ Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.⁵²

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.⁵³ The Court next examined, however, whether the Secretary’s decision to do so was reasonable. The D.C. District Court made the following findings:

⁴⁶ *Id.* at *8 (citations omitted).

⁴⁷ *Id.* at *2.

⁴⁸ 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a “§ 401” hospital.

⁴⁹ *Toledo* at *3.

⁵⁰ *Id.* at *3-4.

⁵¹ *Id.* at *4.

⁵² *Id.* at *5.

⁵³ *Id.* at *6-8.

1. “if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it.”⁵⁴
2. The Secretary’s decision to not provide a capital DSH adjustment was arbitrary because:
 - “The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006.”⁵⁵
 - “[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements.”⁵⁶
 - “The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp.*, 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why ‘added precision’ ‘would not justify the added complication’) (quotation omitted).”⁵⁷
 - “The agency cannot ‘entirely fail[] to consider’ the “relevant data” and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all.”⁵⁸

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because “vacatur of a rule is not an appropriate remedy on review of an adjudication.”⁵⁹ Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants’ eligibility for a capital DSH adjustment.⁶⁰

Providers’ Request for EJR

The Providers state that EJR is appropriate because the they are challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).⁶¹

The Providers are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent

⁵⁴ *Id.* at *11.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at *11-12.

⁵⁹ *Id.* at *12.

⁶⁰ *Id.*

⁶¹ Request for EJR at 2.

with 42 U.S.C. § 1395ww(d)(8)(E) which states that hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1395ww(d)].” The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(E) and 1395ww(g), and the regulation must be found invalid.⁶² Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.

Since the Board is bound by the regulations being challenged,⁶³ namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers’ Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.

Board Decision

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

A. Jurisdiction

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 it as a “self-disallowed cost,” pursuant to the Supreme Court’s reasoning set out in *Bethesda Hospital Association v. Bowen* (“*Bethesda*”).⁶⁴ 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.⁶⁵

On August 21, 2008, new regulations governing the Board were effective.⁶⁶ 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-

⁶² *Id.* at 3.

⁶³ See 42 C.F.R. § 405.1867.

⁶⁴ 108 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.).

⁶⁵ *Bethesda*, 108 S. Ct. at 1258-59.

⁶⁶ 73 Fed. Reg. 30190, 30240 (May 23, 2008).

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*”).⁶⁷ 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.⁶⁸

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

The Board has determined that the challenge involving the capital DSH payment in this case is governed by CMS Ruling CMS-1727-R and that the Board has jurisdiction pursuant to that Ruling since the Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii) for fiscal years ending prior to December 31, 2016. One Provider has appealed from an original NPR and one Provider has appealed from a revised NPR. For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant’s appeal of matters that the Medicare contractor specifically revised within the revised NPR.⁶⁹ The Board notes that the Provider’s revised NPR appeal included within this EJR request was issued after August 21, 2008. The Provider which filed an appeal from revised NPR removed Capital DSH payments, as required for jurisdiction under the provisions of 42 C.F.R. § 405.1889.⁷⁰

The Board also finds that both participants in this CIRP group filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. The amount in controversy also meets the \$50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

⁶⁷ 201 F. Supp. 3d 131 (D.D.C. 2016).

⁶⁸ *Id.* at 142.

⁶⁹ See 42 C.F.R. § 405.1889(b)(1) (2008).

⁷⁰ The Board recognizes that the Provider requested that the NPR be reopened so that the capital DSH at issue could be removed. Pursuant to OIG regulations governing false claims, the Provider had an obligation to make that reopening request since 42 C.F.R. § 412.320(a)(1)(iii) clearly instructs that the Provider had no right to that reimbursement. Thus, through the application of Ruling 1727-R, the Provider can meet the claim-specific dissatisfaction requirement as the Provider is challenging that very regulation.

Finally, the Board notes that the Medicare Contractor filed response to the EJR request noting there are no jurisdictional issues in the case.

B. Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in this group appeal are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(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. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(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. Since this is the only issue under dispute in this case, 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
Ratina Kelly, CPA

FOR THE BOARD:

11/15/2022

 Clayton J. Nix

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

Enclosure: Schedule of Providers

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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RE: *Expedited Judicial Review Determination*
UHS CY 2016 Capital DSH CIRP Group
Case No. 20-1986GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (“Board”) has reviewed the Provider’s October 17, 2022 request for expedited judicial review (“EJR”) in the above-referenced common issue related party (“CIRP”) group appeal.¹ The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Providers are

[C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)², which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1886(d)].”³

Background:

Under the inpatient prospective payment system (“IPPS”), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for

¹ UHS is a health system with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 20-1986GGC for the year 2016. As UHS designated the CIRP group fully formed, the health system is prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): “When the Board has determined that a group appeal brought under paragraph (b)(1) . . . 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.”

² Codified at 42 U.S.C. § 1395ww(d)(8)(E).

³ Request for Expedited Judicial Review at 3 (Oct. 17, 2022) (“EJR Request”). See also Issue Statement – Capital DSH.

operating costs (“operating IPPS”) as set forth at § 1395ww(d); and one for capital costs (“capital IPPS”) as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.⁴ This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board (“MGCRB”) which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area⁵ for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.⁶ This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.⁷ Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁸

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.⁹ One of the adjustments is the hospital-specific Disproportionate Share Hospital (“DSH”) adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.¹⁰

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage (“DPP”).¹¹ As a proxy for utilization by low-income

⁴ Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), available at <https://oig.hhs.gov/oas/reports/region1/11700500.pdf> (last visited Oct. 20, 2022) (“*Significant Vulnerabilities*”).

⁵ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html> (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (“CBSAs”) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).

⁶ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). See also *Significant Vulnerabilities* at 4-5.

⁷ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁸ *Id.*

⁹ See 42 U.S.C. § 1395ww(d)(5).

¹⁰ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

¹¹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.¹²

The DSH adjustment provided under operating IPPS is *not* at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.¹³ OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall*, for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .

(B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;*

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

¹² See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

¹³ Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

(C) In this paragraph, the term “capital-related costs” has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.¹⁴

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary “may provide for an adjustment to account variations in relative costs.” As described below, the Secretary exercised his discretion to establish the *capital* DSH adjustment at issue in this case which is limited in that it **only** applies to *urban* hospitals with 100 or more beds and that serve low income patients.¹⁵

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.¹⁶ In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process), we have the latitude to develop adjustments based on combined costs for the capital prospective payment system.*

We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should

¹⁴ (Underline and italics emphasis added.)

¹⁵ 42 C.F.R. § 412.320(a)(1). See also MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).

¹⁶ 56 Fed. Reg. 43356 (Aug. 30, 1991).

reflect only the higher Medicare costs associated with teaching activity and treating low income patients.¹⁷

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $(\{1 + \text{DSHP}\}^{0.4176} - 1)$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.

Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.¹⁸

In adopting his proposal, the Secretary gave the following justification:

Comment: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.

Response: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also

¹⁷ *Id.* at 43369-70 (emphasis added).

¹⁸ *Id.* at 43377.

be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries.**¹⁹

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(1){ii} of the regulations.²⁰

¹⁹ *Id.* at 43409-10 (bold and underline emphasis added).

²⁰ *Id.*

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as “[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high ‘total government’ usage”:

In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.²¹

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.²²

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare’s payment to recognize these higher Medicare patient care costs.²³

²¹ *Id.* at 43378.

²² *Id.* at 43379.

²³ (Emphasis added.)

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

Comment: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

Response: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will **not** be eligible for capital disproportionate share payments.²⁴

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital’s disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.²⁵

²⁴ (Bold and underline emphasis added.)

²⁵ *Id.* at 43452-53.

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (“BBRA”) and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.²⁶ IPPS hospitals are reclassified per BBRA § 401 are often referred to as “§ 401 hospitals.”

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for **all** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

*A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for **all** purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and **disproportionate share calculations** (§ 412.106) as of the effective date of the reclassification.²⁷*

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes.*** In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific

²⁶ BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

²⁷ 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113.* In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106–113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

*We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. **Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify.** As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.²⁸*

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and

²⁸ 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

Services Administration which is available via the ORHP website at <http://www.nal.usda.gov/orph> or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.²⁹

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase “the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area”, it would appear that hospitals reclassified from urban to rural were *not* eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b) through (g)** of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.**³⁰

²⁹ *Id.* at 47048.

³⁰ (Bold and underline emphasis added.)

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. *Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS*

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.³¹ Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas (“CBSAs”) and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.³² On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas (“MSAs”) and the new Micropolitan Areas based on Census 2000 data.³³

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB’s new CBSA designations.³⁴ With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

³¹ Pub. L. 108–173

³² 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

³³ *Id.*

³⁴ 69 Fed. Reg. 48916 (Aug. 11, 2004).

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result

of redesignation of an MSA by the Executive Office of Management and Budget.³⁵

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: “A hospital is classified as a ‘disproportionate share hospital’ for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area.”³⁶ As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital’s location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.³⁷

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB’s new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for

³⁵ *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

³⁶ (Emphasis added.)

³⁷ 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.

As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.³⁸

³⁸ 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary³⁹ announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.⁴⁰

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OMB's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.⁴¹

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital

³⁹ of the Department of Health and Human Services.

⁴⁰ 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

⁴¹ *Id.*

reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.⁴²

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.⁴³

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.⁴⁴

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* (“*Toledo*”),⁴⁵ wherein the hospital made the following contentions:

⁴² *Id.*

⁴³ *Id.*

⁴⁴ (Bold emphasis added.)

⁴⁵ 2021 WL 4502052 (D.D.C. 2021).

Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to “take into account” relative costs of capital for various hospital types and areas of location, as subsection (g) requires.⁴⁶

In *Toledo*, U.S. District Court for the District of Columbia (“D.C. District Court”) outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.⁴⁷ The Court also noted how Congress enacted legislation in 1999⁴⁸ allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.⁴⁹ The Court also noted the separate IPPS payment for a hospital’s *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).⁵⁰ The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.⁵¹

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants’ Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.⁵²

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.⁵³ The Court next examined, however, whether the Secretary’s decision to do so was reasonable. The D.C. District Court made the following findings:

⁴⁶ *Id.* at *8 (citations omitted).

⁴⁷ *Id.* at *2.

⁴⁸ 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a “§ 401” hospital.

⁴⁹ *Toledo* at *3.

⁵⁰ *Id.* at *3-4.

⁵¹ *Id.* at *4.

⁵² *Id.* at *5.

⁵³ *Id.* at *6-8.

1. “if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it.”⁵⁴
2. The Secretary’s decision to not provide a capital DSH adjustment was arbitrary because:
 - “The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006.”⁵⁵
 - “[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements.”⁵⁶
 - “The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp.*, 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why ‘added precision’ ‘would not justify the added complication’) (quotation omitted).”⁵⁷
 - “The agency cannot ‘entirely fail[] to consider’ the “relevant data” and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all.”⁵⁸

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because “vacatur of a rule is not an appropriate remedy on review of an adjudication.”⁵⁹ Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants’ eligibility for a capital DSH adjustment.⁶⁰

Providers’ Request for EJR

The Providers state that EJR is appropriate because the they are challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).⁶¹

The Providers are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent

⁵⁴ *Id.* at *11.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at *11-12.

⁵⁹ *Id.* at *12.

⁶⁰ *Id.*

⁶¹ Request for EJR at 2.

with 42 U.S.C. § 1395ww(d)(8)(E) which states that hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1395ww(d)].” The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(E) and 1395ww(g), and the regulation must be found invalid.⁶² Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.

Since the Board is bound by the regulations being challenged,⁶³ namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers’ Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.

Board Decision

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

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,⁶⁴ the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.⁶⁵ The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider’s cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement (“NPR”) issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the “claim-specific dissatisfaction requirement”). As all of the participants in this case have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

⁶² *Id.* at 3.

⁶³ *See* 42 C.F.R. § 405.1867.

⁶⁴ 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

⁶⁵ *Id.* at 70555.

The participants that comprise this CIRP group appeal have filed appeals involving fiscal years ending December 31, 2016. Both Providers have appealed from original NPRs. Based on its review of the record, the Board finds that both participants in this CIRP group filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the \$50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j), specifies that, in order for a specific item to be eligible for potential reimbursement, the provider must include an appropriate cost report claim for that specific item:

(j) Substantive reimbursement requirement of an appropriate cost report claim—

(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—

(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.

(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) addresses when the Board must examine a provider's compliance with § 413.24(j):

- (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.⁶⁶**

These regulations are applicable to the cost reporting periods under appeal for both of the participants in this group, which both have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"⁶⁷ with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) **if** a party to the appeal questions whether there was an appropriate claim made.⁶⁸ In this CIRP

⁶⁶ (Bold emphasis added.)

⁶⁷ 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

⁶⁸ See 42 C.F.R. § 405.1873(a).

group case, the Medicare Contractor has failed to file a Substantive Claim Challenge⁶⁹ consistent with § 405.1873(a) within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers in the case.⁷⁰

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,⁷¹ the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

The Board also notes that the Medicare Contractor filed a thirty day jurisdictional review document pursuant to Board Rules 15.2 and 44.4.2 noting there are no jurisdictional issues in the case.

C. Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in this group appeal are entitled to a hearing before the Board;
- 2) The Providers' cost reports included appropriate claims for a specific item as required by 42 C.F.R. § 405.1873(a);
- 3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), 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 the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(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

⁶⁹ Board Rule 44.5 states: "The Board adoption 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."

⁷⁰ In this case, the Medicare Contractor filed a response noting that there are no jurisdictional or substantive claim impediments and that EJR is appropriate. Response to Provider's Request for Expedited Judicial Review (Oct. 20, 2022).

⁷¹ The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, 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
Ratina Kelly, CPA

FOR THE BOARD:

11/15/2022

 Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Bill Tisdale, Novitas Solutions, Inc. (J-H)
Wilson Leong, FSS



DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
UHS CY 2017 Capital DSH CIRP Group
Case No. 21-0318GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (“Board”) has reviewed the Provider’s October 17, 2022 request for expedited judicial review (“EJR”) in the above-referenced common issue related party (“CIRP”) group appeal.¹ The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Providers are

[C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)², which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1886(d)].”³

Background

Under the inpatient prospective payment system (“IPPS”), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for

¹ UHS is a health system with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 21-0318GC for the year 2017. As UHS designated the CIRP group fully formed, the health system is prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): “When the Board has determined that a group appeal brought under paragraph (b)(1) . . . 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.”

² Codified at 42 U.S.C. § 1395ww(d)(8)(E).

³ Request for Expedited Judicial Review at 3 (Oct. 17, 2022) (“EJR Request”). See also Issue Statement – Capital DSH.

operating costs (“operating IPPS”) as set forth at § 1395ww(d); and one for capital costs (“capital IPPS”) as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.⁴ This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board (“MGCRB”) which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area⁵ for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.⁶ This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.⁷ Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁸

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.⁹ One of the adjustments is the hospital-specific Disproportionate Share Hospital (“DSH”) adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.¹⁰

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage (“DPP”).¹¹ As a proxy for utilization by low-income

⁴ Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), available at <https://oig.hhs.gov/oas/reports/region1/11700500.pdf> (last visited Oct. 20, 2022) (“*Significant Vulnerabilities*”).

⁵ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html> (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (“CBSAs”) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).

⁶ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). See also *Significant Vulnerabilities* at 4-5.

⁷ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁸ *Id.*

⁹ See 42 U.S.C. § 1395ww(d)(5).

¹⁰ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

¹¹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.¹²

The DSH adjustment provided under operating IPPS is *not* at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.¹³ OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall*, for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .

(B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;*

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

¹² See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

¹³ Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

(C) In this paragraph, the term “capital-related costs” has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.¹⁴

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary “may provide for an adjustment to account variations in relative costs.” As described below, the Secretary exercised his discretion to establish the *capital* DSH adjustment at issue in this case which is limited in that it **only** applies to *urban* hospitals with 100 or more beds and that serve low income patients.¹⁵

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.¹⁶ In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process), we have the latitude to develop adjustments based on combined costs for the capital prospective payment system.*

We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should

¹⁴ (Underline and italics emphasis added.)

¹⁵ 42 C.F.R. § 412.320(a)(1). See also MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).

¹⁶ 56 Fed. Reg. 43356 (Aug. 30, 1991).

reflect only the higher Medicare costs associated with teaching activity and treating low income patients.¹⁷

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $(\{1 + \text{DSHP}\}^{0.4176} - 1)$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.

Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.¹⁸

In adopting his proposal, the Secretary gave the following justification:

Comment: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.

Response: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also

¹⁷ *Id.* at 43369-70 (emphasis added).

¹⁸ *Id.* at 43377.

be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries.**¹⁹

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(1){ii} of the regulations.²⁰

¹⁹ *Id.* at 43409-10 (bold and underline emphasis added).

²⁰ *Id.*

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as “[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high ‘total government’ usage”:

In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.²¹

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.²²

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare’s payment to recognize these higher Medicare patient care costs.²³

²¹ *Id.* at 43378.

²² *Id.* at 43379.

²³ (Emphasis added.)

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

Comment: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

Response: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will **not** be eligible for capital disproportionate share payments.²⁴

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital’s disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.²⁵

²⁴ (Bold and underline emphasis added.)

²⁵ *Id.* at 43452-53.

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (“BBRA”) and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.²⁶ IPPS hospitals are reclassified per BBRA § 401 are often referred to as “§ 401 hospitals.”

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

*A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and ***disproportionate share calculations*** (§ 412.106) as of the effective date of the reclassification.²⁷*

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes.*** In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific

²⁶ BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

²⁷ 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113.* In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106–113, which authorizes a 30-percent expansion in a rural hospital’s resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

*We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. **Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify.** As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.²⁸*

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and

²⁸ 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

Services Administration which is available via the ORHP website at <http://www.nal.usda.gov/orph> or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.²⁹

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase “the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area”, it would appear that hospitals reclassified from urban to rural were *not* eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b) through (g)** of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.**³⁰

²⁹ *Id.* at 47048.

³⁰ (Bold and underline emphasis added.)

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. *Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS*

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.³¹ Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas (“CBSAs”) and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.³² On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas (“MSAs”) and the new Micropolitan Areas based on Census 2000 data.³³

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB’s new CBSA designations.³⁴ With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

³¹ Pub. L. 108–173

³² 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

³³ *Id.*

³⁴ 69 Fed. Reg. 48916 (Aug. 11, 2004).

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result

of redesignation of an MSA by the Executive Office of Management and Budget.³⁵

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: “A hospital is classified as a ‘disproportionate share hospital’ for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area.”³⁶ As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital’s location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.³⁷

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB’s new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for

³⁵ *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

³⁶ (Emphasis added.)

³⁷ 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.

As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.³⁸

³⁸ 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary³⁹ announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.⁴⁰

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OMB's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.⁴¹

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital

³⁹ of the Department of Health and Human Services.

⁴⁰ 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

⁴¹ *Id.*

reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.⁴²

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.⁴³

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.⁴⁴

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* (“*Toledo*”),⁴⁵ wherein the hospital made the following contentions:

⁴² *Id.*

⁴³ *Id.*

⁴⁴ (Bold emphasis added.)

⁴⁵ 2021 WL 4502052 (D.D.C. 2021).

Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to “take into account” relative costs of capital for various hospital types and areas of location, as subsection (g) requires.⁴⁶

In *Toledo*, U.S. District Court for the District of Columbia (“D.C. District Court”) outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.⁴⁷ The Court also noted how Congress enacted legislation in 1999⁴⁸ allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.⁴⁹ The Court also noted the separate IPPS payment for a hospital’s *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).⁵⁰ The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.⁵¹

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants’ Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.⁵²

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.⁵³ The Court next examined, however, whether the Secretary’s decision to do so was reasonable. The D.C. District Court made the following findings:

⁴⁶ *Id.* at *8 (citations omitted).

⁴⁷ *Id.* at *2.

⁴⁸ 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a “§ 401” hospital.

⁴⁹ *Toledo* at *3.

⁵⁰ *Id.* at *3-4.

⁵¹ *Id.* at *4.

⁵² *Id.* at *5.

⁵³ *Id.* at *6-8.

1. “if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it.”⁵⁴
2. The Secretary’s decision to not provide a capital DSH adjustment was arbitrary because:
 - “The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006.”⁵⁵
 - “[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements.”⁵⁶
 - “The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp.*, 797 F.3d at 1161 (upholding Secretary’s regulation where the Secretary explained why ‘added precision’ ‘would not justify the added complication’) (quotation omitted).”⁵⁷
 - “The agency cannot ‘entirely fail[] to consider’ the “relevant data” and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all.”⁵⁸

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because “vacatur of a rule is not an appropriate remedy on review of an adjudication.”⁵⁹ Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants’ eligibility for a capital DSH adjustment.⁶⁰

Providers’ Request for EJR

The Providers state that EJR is appropriate because the they are challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).⁶¹

The Providers are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent

⁵⁴ *Id.* at *11.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at *11-12.

⁵⁹ *Id.* at *12.

⁶⁰ *Id.*

⁶¹ Request for EJR at 2.

with 42 U.S.C. § 1395ww(d)(8)(E) which states that hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1395ww(d)].” The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(E) and 1395ww(g), and the regulation must be found invalid.⁶² Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.

Since the Board is bound by the regulations being challenged,⁶³ namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers’ Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.

Board Decision

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

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,⁶⁴ the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.⁶⁵ The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider’s cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement (“NPR”) issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the “claim-specific dissatisfaction requirement”). As all of the participants in this case have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

⁶² *Id.* at 3.

⁶³ *See* 42 C.F.R. § 405.1867.

⁶⁴ 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

⁶⁵ *Id.* at 70555.

The participants that comprise this CIRP group appeal have filed appeals involving fiscal years ending December 31, 2017. Both Providers have appealed from original NPRs. Based on its review of the record, the Board finds that both participants in this CIRP group filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the \$50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j), specifies that, in order for a specific item to be eligible for potential reimbursement, the provider must include an appropriate cost report claim for that specific item:

(j) Substantive reimbursement requirement of an appropriate cost report claim—

(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—

(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.

(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) addresses when the Board must examine a provider's compliance with § 413.24(j):

- (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.⁶⁶**

These regulations are applicable to the cost reporting periods under appeal for both of the participants in this group, which both have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"⁶⁷ with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) **if** a party to the appeal questions whether there was an appropriate claim made.⁶⁸ In this CIRP

⁶⁶ (Bold emphasis added.)

⁶⁷ 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

⁶⁸ See 42 C.F.R. § 405.1873(a).

group case, the Medicare Contractor has failed to file a Substantive Claim Challenge⁶⁹ consistent with § 405.1873(a) within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers in the case.⁷⁰

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,⁷¹ the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

The Board also notes that the Medicare Contractor filed a thirty day letter pursuant to Board Rules 15.2 & 44.4.2 noting there are no jurisdictional issues in the case.

C. Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in this group appeal are entitled to a hearing before the Board;
- 2) The Providers' cost reports included appropriate claims for a specific item as required by 42 C.F.R. § 405.1873(a);
- 3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), 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 the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(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

⁶⁹ Board Rule 44.5 states: "The Board adoption 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."

⁷⁰ In this case, the Medicare Contractor filed a response noting that there are no jurisdictional or substantive claim impediments and that EJR is appropriate. Response to Provider's Request for Expedited Judicial Review (Oct. 20, 2022).

⁷¹ The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, 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
Ratina Kelly, CPA

FOR THE BOARD:

11/15/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Bill Tisdale, Novitas Solutions (J-H)
Wilson Leong, FSS



DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
Geisinger Health CY 2018 Capital DSH CIRP Group
Case No. 21-1439GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (“Board”) has reviewed the Provider’s October 17, 2022 request for expedited judicial review (“EJR”) in the above-referenced common issue related party (“CIRP”) group appeal.¹ The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Providers are:

[C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)², which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1886(d)].”³

Background

Under the inpatient prospective payment system (“IPPS”), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for

¹ Geisinger Health is a health system with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 21-1439GC for the year 2018. As Geisinger Health designated the CIRP group fully formed, the health system is prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): “When the Board has determined that a group appeal brought under paragraph (b)(1) . . . 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.”

² Codified at 42 U.S.C. § 1395ww(d)(8)(E).

³ Request for Expedited Judicial Review at 3 (Oct. 17, 2022) (“EJR Request”). See also Issue Statement – Capital DSH.

operating costs (“operating IPPS”) as set forth at § 1395ww(d); and one for capital costs (“capital IPPS”) as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.⁴ This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board (“MGCRB”) which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area⁵ for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.⁶ This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.⁷ Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁸

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.⁹ One of the adjustments is the hospital-specific Disproportionate Share Hospital (“DSH”) adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.¹⁰

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage (“DPP”).¹¹ As a proxy for utilization by low-income

⁴ Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), available at <https://oig.hhs.gov/oas/reports/region1/11700500.pdf> (last visited Oct. 20, 2022) (“*Significant Vulnerabilities*”).

⁵ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html> (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (“CBSAs”) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).

⁶ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). See also *Significant Vulnerabilities* at 4-5.

⁷ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁸ *Id.*

⁹ See 42 U.S.C. § 1395ww(d)(5).

¹⁰ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

¹¹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.¹²

The DSH adjustment provided under operating IPPS is *not* at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.¹³ OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall*, for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .

(B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;*

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

¹² See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

¹³ Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

(C) In this paragraph, the term “capital-related costs” has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.¹⁴

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary “may provide for an adjustment to account variations in relative costs.” As described below, the Secretary exercised his discretion to establish the *capital* DSH adjustment at issue in this case which is limited in that it **only** applies to *urban* hospitals with 100 or more beds and that serve low income patients.¹⁵

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.¹⁶ In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process), we have the latitude to develop adjustments based on combined costs for the capital prospective payment system.*

We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should

¹⁴ (Underline and italics emphasis added.)

¹⁵ 42 C.F.R. § 412.320(a)(1). See also MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).

¹⁶ 56 Fed. Reg. 43356 (Aug. 30, 1991).

reflect only the higher Medicare costs associated with teaching activity and treating low income patients.¹⁷

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $(\{1 + \text{DSHP}\}^{0.4176} - 1)$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.

Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.¹⁸

In adopting his proposal, the Secretary gave the following justification:

Comment: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.

Response: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also

¹⁷ *Id.* at 43369-70 (emphasis added).

¹⁸ *Id.* at 43377.

be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries.**¹⁹

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(1){ii} of the regulations.²⁰

¹⁹ *Id.* at 43409-10 (bold and underline emphasis added).

²⁰ *Id.*

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as “[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high ‘total government’ usage”:

In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.²¹

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.²²

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare’s payment to recognize these higher Medicare patient care costs.²³

²¹ *Id.* at 43378.

²² *Id.* at 43379.

²³ (Emphasis added.)

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

Comment: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

Response: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will **not** be eligible for capital disproportionate share payments.²⁴

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital’s disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.²⁵

²⁴ (Bold and underline emphasis added.)

²⁵ *Id.* at 43452-53.

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (“BBRA”) and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.²⁶ IPPS hospitals are reclassified per BBRA § 401 are often referred to as “§ 401 hospitals.”

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for all purposes under operating IPPS, including the DSH adjustment for operating IPPS:

*A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and disproportionate share calculations (§ 412.106) as of the effective date of the reclassification.*²⁷

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes.*** In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific

²⁶ BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

²⁷ 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113.* In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106–113, which authorizes a 30-percent expansion in a rural hospital’s resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

*We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. **Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify.** As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.²⁸*

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and

²⁸ 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

Services Administration which is available via the ORHP website at [http:// www.nal.usda.gov/orph](http://www.nal.usda.gov/orph) or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.²⁹

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase “the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area”, it would appear that hospitals reclassified from urban to rural were *not* eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b) through (g)** of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.**³⁰

²⁹ *Id.* at 47048.

³⁰ (Bold and underline emphasis added.)

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. *Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS*

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.³¹ Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas (“CBSAs”) and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.³² On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas (“MSAs”) and the new Micropolitan Areas based on Census 2000 data.³³

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB’s new CBSA designations.³⁴ With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

³¹ Pub. L. 108–173

³² 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

³³ *Id.*

³⁴ 69 Fed. Reg. 48916 (Aug. 11, 2004).

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result

of redesignation of an MSA by the Executive Office of Management and Budget.³⁵

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: “A hospital is classified as a ‘disproportionate share hospital’ for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area.”³⁶ As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital’s location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.³⁷

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB’s new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for

³⁵ *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

³⁶ (Emphasis added.)

³⁷ 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.

As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.³⁸

³⁸ 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary³⁹ announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.⁴⁰

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OMB's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.⁴¹

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital

³⁹ of the Department of Health and Human Services.

⁴⁰ 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

⁴¹ *Id.*

reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.⁴²

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.⁴³

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.⁴⁴

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* (“*Toledo*”),⁴⁵ wherein the hospital made the following contentions:

⁴² *Id.*

⁴³ *Id.*

⁴⁴ (Bold emphasis added.)

⁴⁵ 2021 WL 4502052 (D.D.C. 2021).

Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to “take into account” relative costs of capital for various hospital types and areas of location, as subsection (g) requires.⁴⁶

In *Toledo*, U.S. District Court for the District of Columbia (“D.C. District Court”) outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.⁴⁷ The Court also noted how Congress enacted legislation in 1999⁴⁸ allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.⁴⁹ The Court also noted the separate IPPS payment for a hospital’s *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).⁵⁰ The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.⁵¹

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants’ Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.⁵²

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.⁵³ The Court next examined, however, whether the Secretary’s decision to do so was reasonable. The D.C. District Court made the following findings:

⁴⁶ *Id.* at *8 (citations omitted).

⁴⁷ *Id.* at *2.

⁴⁸ 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a “§ 401” hospital.

⁴⁹ *Toledo* at *3.

⁵⁰ *Id.* at *3-4.

⁵¹ *Id.* at *4.

⁵² *Id.* at *5.

⁵³ *Id.* at *6-8.

1. “if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it.”⁵⁴
2. The Secretary’s decision to not provide a capital DSH adjustment was arbitrary because:
 - “The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006.”⁵⁵
 - “[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements.”⁵⁶
 - “The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp.*, 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why ‘added precision’ ‘would not justify the added complication’) (quotation omitted).”⁵⁷
 - “The agency cannot ‘entirely fail[] to consider’ the “relevant data” and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all.”⁵⁸

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because “vacatur of a rule is not an appropriate remedy on review of an adjudication.”⁵⁹ Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants’ eligibility for a capital DSH adjustment.⁶⁰

Providers’ Request for EJR

The Providers state that EJR is appropriate because the they are challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).⁶¹

The Providers are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent

⁵⁴ *Id.* at *11.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at *11-12.

⁵⁹ *Id.* at *12.

⁶⁰ *Id.*

⁶¹ Request for EJR at 2.

with 42 U.S.C. § 1395ww(d)(8)(E) which states that hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1395ww(d)].” The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(E) and 1395ww(g), and the regulation must be found invalid.⁶² Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.

Since the Board is bound by the regulations being challenged,⁶³ namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers’ Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.

Board Decision

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

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,⁶⁴ the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.⁶⁵ The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider’s cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement (“NPR”) issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the “claim-specific dissatisfaction

⁶² *Id.* at 3.

⁶³ *See* 42 C.F.R. § 405.1867.

⁶⁴ 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

⁶⁵ *Id.* at 70555.

requirement”). As all of the participants in this case have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The participants that comprise this CIRP group appeal have filed appeals involving fiscal years ending June 30, 2018. Both Providers have appealed from original NPRs. Based on its review of the record, the Board finds that both participants in this CIRP group filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the \$50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j), specifies that, in order for a specific item to be eligible for potential reimbursement, the provider must include an appropriate cost report claim for that specific item:

(j) Substantive reimbursement requirement of an appropriate cost report claim—

(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—

(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.

(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) addresses when the Board must examine a provider's compliance with § 413.24(j):

(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.**⁶⁶

These regulations are applicable to the cost reporting periods under appeal for both of the participants in this group, which both have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"⁶⁷ with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument)

⁶⁶ (Bold emphasis added.)

⁶⁷ 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

if a party to the appeal questions whether there was an appropriate claim made.⁶⁸ In this CIRP group case, the Medicare Contractor has failed to file a Substantive Claim Challenge⁶⁹ consistent with § 405.1873(a) within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers in the case.⁷⁰

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,⁷¹ the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJIR request pursuant to 42 C.F.R. § 405.1873(d).

The Board also notes that the Medicare Contractor filed a thirty day letter pursuant to Board Rules 15.2 & 44.4.2 noting there are no jurisdictional issues in the case.

C. Board's Decision Regarding the EJIR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in this group appeal are entitled to a hearing before the Board;
- 2) The Providers' cost reports included appropriate claims for a specific item as required by 42 C.F.R. § 405.1873(a);
- 3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), 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 the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers'

⁶⁸ See 42 C.F.R. § 405.1873(a).

⁶⁹ Board Rule 44.5 states: "The Board adoption 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."

⁷⁰ In this case, the Medicare Contractor filed a response noting that there are no jurisdictional or substantive claim impediments and that EJIR is appropriate. Response to Provider's Request for Expedited Judicial Review (Oct. 20, 2022).

⁷¹ The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, 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
Ratina Kelly, CPA

FOR THE BOARD

11/15/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Bruce Snyder, Novitas Solutions (J-L)
Wilson Leong, FSS



DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
Sanford Health CY 2017 Capital DSH CIRP Group
Case No. 21-1625GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (“Board”) has reviewed the Provider’s October 17, 2022 request for expedited judicial review (“EJR”) in the above-referenced common issue related party (“CIRP”) group appeal.¹ The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Providers are

[C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)², which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1886(d)].”³

Background

Under the inpatient prospective payment system (“IPPS”), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for

¹ Sanford Health is a health system with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 21-1625GC for the year 2017. As Sanford Health designated the CIRP group fully formed, the health system is prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): “When the Board has determined that a group appeal brought under paragraph (b)(1) . . . 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.”

² Codified at 42 U.S.C. § 1395ww(d)(8)(E).

³ Request for Expedited Judicial Review at 3 (Oct. 17, 2022) (“EJR Request”). *See also* Issue Statement – Capital DSH.

operating costs (“operating IPPS”) as set forth at § 1395ww(d); and one for capital costs (“capital IPPS”) as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.⁴ This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board (“MGCRB”) which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area⁵ for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.⁶ This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.⁷ Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁸

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.⁹ One of the adjustments is the hospital-specific Disproportionate Share Hospital (“DSH”) adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.¹⁰

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage (“DPP”).¹¹ As a proxy for utilization by low-income

⁴ Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), available at <https://oig.hhs.gov/oas/reports/region1/11700500.pdf> (last visited Oct. 20, 2022) (“*Significant Vulnerabilities*”).

⁵ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html> (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (“CBSAs”) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).

⁶ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). See also *Significant Vulnerabilities* at 4-5.

⁷ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁸ *Id.*

⁹ See 42 U.S.C. § 1395ww(d)(5).

¹⁰ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

¹¹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.¹²

The DSH adjustment provided under operating IPPS is *not* at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.¹³ OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall*, for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .

(B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;*

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

¹² See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

¹³ Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

(C) In this paragraph, the term “capital-related costs” has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.¹⁴

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary “may provide for an adjustment to account variations in relative costs.” As described below, the Secretary exercised his discretion to establish the *capital* DSH adjustment at issue in this case which is limited in that it **only** applies to *urban* hospitals with 100 or more beds and that serve low income patients.¹⁵

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.¹⁶ In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process), we have the latitude to develop adjustments based on combined costs for the capital prospective payment system.*

We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should

¹⁴ (Underline and italics emphasis added.)

¹⁵ 42 C.F.R. § 412.320(a)(1). See also MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).

¹⁶ 56 Fed. Reg. 43356 (Aug. 30, 1991).

reflect only the higher Medicare costs associated with teaching activity and treating low income patients.¹⁷

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $(\{1 + \text{DSHP}\}^{0.4176} - 1)$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.

Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.¹⁸

In adopting his proposal, the Secretary gave the following justification:

Comment: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.

Response: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also

¹⁷ *Id.* at 43369-70 (emphasis added).

¹⁸ *Id.* at 43377.

be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries.**¹⁹

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(1){ii} of the regulations.²⁰

¹⁹ *Id.* at 43409-10 (bold and underline emphasis added).

²⁰ *Id.*

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as “[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high ‘total government’ usage”:

In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.²¹

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.²²

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare’s payment to recognize these higher Medicare patient care costs.²³

²¹ *Id.* at 43378.

²² *Id.* at 43379.

²³ (Emphasis added.)

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

Comment: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

Response: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will **not** be eligible for capital disproportionate share payments.²⁴

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital’s disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.²⁵

²⁴ (Bold and underline emphasis added.)

²⁵ *Id.* at 43452-53.

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (“BBRA”) and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.²⁶ IPPS hospitals are reclassified per BBRA § 401 are often referred to as “§ 401 hospitals.”

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for all purposes under operating IPPS, including the DSH adjustment for operating IPPS:

*A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and disproportionate share calculations (§ 412.106) as of the effective date of the reclassification.*²⁷

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes.*** In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific

²⁶ BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

²⁷ 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113.* In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106–113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

*We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. **Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify.** As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.²⁸*

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and

²⁸ 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

Services Administration which is available via the ORHP website at <http://www.nal.usda.gov/orph> or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.²⁹

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase “the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area”, it would appear that hospitals reclassified from urban to rural were *not* eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b) through (g)** of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.**³⁰

²⁹ *Id.* at 47048.

³⁰ (Bold and underline emphasis added.)

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. *Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS*

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.³¹ Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas (“CBSAs”) and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.³² On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas (“MSAs”) and the new Micropolitan Areas based on Census 2000 data.³³

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB’s new CBSA designations.³⁴ With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

³¹ Pub. L. 108–173

³² 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

³³ *Id.*

³⁴ 69 Fed. Reg. 48916 (Aug. 11, 2004).

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result

of redesignation of an MSA by the Executive Office of Management and Budget.³⁵

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: “A hospital is classified as a ‘disproportionate share hospital’ for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area.”³⁶ As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital’s location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.³⁷

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB’s new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for

³⁵ *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

³⁶ (Emphasis added.)

³⁷ 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.

As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.³⁸

³⁸ 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary³⁹ announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.⁴⁰

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OMB's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.⁴¹

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital

³⁹ of the Department of Health and Human Services.

⁴⁰ 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

⁴¹ *Id.*

reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.⁴²

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.⁴³

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.⁴⁴

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* (“*Toledo*”),⁴⁵ wherein the hospital made the following contentions:

⁴² *Id.*

⁴³ *Id.*

⁴⁴ (Bold emphasis added.)

⁴⁵ 2021 WL 4502052 (D.D.C. 2021).

Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to “take into account” relative costs of capital for various hospital types and areas of location, as subsection (g) requires.⁴⁶

In *Toledo*, U.S. District Court for the District of Columbia (“D.C. District Court”) outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.⁴⁷ The Court also noted how Congress enacted legislation in 1999⁴⁸ allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.⁴⁹ The Court also noted the separate IPPS payment for a hospital’s *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).⁵⁰ The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.⁵¹

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants’ Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.⁵²

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.⁵³ The Court next examined, however, whether the Secretary’s decision to do so was reasonable. The D.C. District Court made the following findings:

⁴⁶ *Id.* at *8 (citations omitted).

⁴⁷ *Id.* at *2.

⁴⁸ 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a “§ 401” hospital.

⁴⁹ *Toledo* at *3.

⁵⁰ *Id.* at *3-4.

⁵¹ *Id.* at *4.

⁵² *Id.* at *5.

⁵³ *Id.* at *6-8.

1. “if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it.”⁵⁴
2. The Secretary’s decision to not provide a capital DSH adjustment was arbitrary because:
 - “The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006.”⁵⁵
 - “[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements.”⁵⁶
 - “The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp.*, 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why ‘added precision’ ‘would not justify the added complication’) (quotation omitted).”⁵⁷
 - “The agency cannot ‘entirely fail[] to consider’ the “relevant data” and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all.”⁵⁸

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because “vacatur of a rule is not an appropriate remedy on review of an adjudication.”⁵⁹ Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants’ eligibility for a capital DSH adjustment.⁶⁰

Providers’ Request for EJR

The Providers state that EJR is appropriate because the they are challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).⁶¹

The Providers are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent

⁵⁴ *Id.* at *11.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at *11-12.

⁵⁹ *Id.* at *12.

⁶⁰ *Id.*

⁶¹ Request for EJR at 2.

with 42 U.S.C. § 1395ww(d)(8)(E) which states that hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1395ww(d)].” The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(E) and 1395ww(g), and the regulation must be found invalid.⁶² Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.

Since the Board is bound by the regulations being challenged,⁶³ namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers’ Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.

Board Decision

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

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,⁶⁴ the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.⁶⁵ The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider’s cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement (“NPR”) issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the “claim-specific dissatisfaction requirement”). As all of the participants in this case have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

⁶² *Id.* at 3.

⁶³ *See* 42 C.F.R. § 405.1867.

⁶⁴ 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

⁶⁵ *Id.* at 70555.

The participants that comprise this CIRP group appeal have filed appeals involving fiscal years ending June 30, 2017. Both Providers appealed from original NPRs. Based on its review of the record, the Board finds that both participants in this CIRP group filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the \$50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j), specifies that, in order for a specific item to be eligible for potential reimbursement, the provider must include an appropriate cost report claim for that specific item:

(j) Substantive reimbursement requirement of an appropriate cost report claim—

(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—

(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.

(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) addresses when the Board must examine a provider's compliance with § 413.24(j):

- (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.⁶⁶**

These regulations are applicable to the cost reporting periods under appeal for both of the participants in this group, which both have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"⁶⁷ with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) **if** a party to the appeal questions whether there was an appropriate claim made.⁶⁸ In this CIRP

⁶⁶ (Bold emphasis added.)

⁶⁷ 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

⁶⁸ See 42 C.F.R. § 405.1873(a).

group case, the Medicare Contractor has failed to file a Substantive Claim Challenge⁶⁹ consistent with § 405.1873(a) within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers in the case.⁷⁰

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,⁷¹ the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

The Board also notes that the Medicare Contractor filed jurisdictional review documents on two separate occasions after the group was fully formed noting there are no jurisdictional issues in the case.

C. Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in this group appeal are entitled to a hearing before the Board;
- 2) The Providers' cost reports included appropriate claims for a specific item as required by 42 C.F.R. § 405.1873(a);
- 3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), 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 the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(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

⁶⁹ Board Rule 44.5 states: "The Board adoption 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."

⁷⁰ In this case, the Medicare Contractor filed a response noting that there are no jurisdictional or substantive claim impediments and that EJR is appropriate. Response to Provider's Request for Expedited Judicial Review (Oct. 20, 2022).

⁷¹ The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, 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
Ratina Kelly, CPA

FOR THE BOARD:

11/15/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: John Bloom, Noridian Healthcare Solutions (J-F)
Wilson Leong, FSS



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RE: ***Expedited Judicial Review Determination***
Univ. of Rochester CY 2018 Capital DSH CIRP Group
Case No. 21-1782GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (“Board”) has reviewed the Provider’s October 17, 2022 request for expedited judicial review (“EJR”) in the above-referenced common issue related party (“CRIP”) group appeal.¹ The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Providers are:

[C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)^[2], which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1886(d)].”³

Background

Under the inpatient prospective payment system (“IPPS”), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for

¹ The University of Rochester Medical Center is a health system with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 22-0638GGC for the year 2017. As the health system designated the CIRP group fully formed, it is prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): “When the Board has determined that a group appeal brought under paragraph (b)(1) . . . 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.”

² Codified at 42 U.S.C. § 1395ww(d)(8)(E).

³ Codified at 42 U.S.C. § 1395ww(d)(8)(E).

³ Request for Expedited Judicial Review at 3 (Oct. 17, 2022) (“EJR Request”). See also Issue Statement – Capital DSH.

operating costs (“operating IPPS”) as set forth at § 1395ww(d); and one for capital costs (“capital IPPS”) as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.⁴ This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board (“MGCRB”) which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area⁵ for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.⁶ This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.⁷ Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁸

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.⁹ One of the adjustments is the hospital-specific Disproportionate Share Hospital (“DSH”) adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.¹⁰

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage (“DPP”).¹¹ As a proxy for utilization by low-income

⁴ Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), available at <https://oig.hhs.gov/oas/reports/region1/11700500.pdf> (last visited Oct. 20, 2022) (“*Significant Vulnerabilities*”).

⁵ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html> (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (“CBSAs”) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).

⁶ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). See also *Significant Vulnerabilities* at 4-5.

⁷ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁸ *Id.*

⁹ See 42 U.S.C. § 1395ww(d)(5).

¹⁰ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

¹¹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.¹²

The DSH adjustment provided under operating IPPS is *not* at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.¹³ OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall*, for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .

(B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;*

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

¹² See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

¹³ Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

(C) In this paragraph, the term “capital-related costs” has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.¹⁴

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary “may provide for an adjustment to account variations in relative costs.” As described below, the Secretary exercised his discretion to establish the *capital* DSH adjustment at issue in this case which is limited in that it **only** applies to *urban* hospitals with 100 or more beds and that serve low income patients.¹⁵

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.¹⁶ In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process), we have the latitude to develop adjustments based on combined costs for the capital prospective payment system.*

We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should

¹⁴ (Underline and italics emphasis added.)

¹⁵ 42 C.F.R. § 412.320(a)(1). See also MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).

¹⁶ 56 Fed. Reg. 43356 (Aug. 30, 1991).

reflect only the higher Medicare costs associated with teaching activity and treating low income patients.¹⁷

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $(\{1 + \text{DSHP}\}^{0.4176} - 1)$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.

Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.¹⁸

In adopting his proposal, the Secretary gave the following justification:

Comment: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.

Response: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also

¹⁷ *Id.* at 43369-70 (emphasis added).

¹⁸ *Id.* at 43377.

be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries.**¹⁹

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(1){ii} of the regulations.²⁰

¹⁹ *Id.* at 43409-10 (bold and underline emphasis added).

²⁰ *Id.*

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as “[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high ‘total government’ usage”:

In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.²¹

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.²²

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare’s payment to recognize these higher Medicare patient care costs.²³

²¹ *Id.* at 43378.

²² *Id.* at 43379.

²³ (Emphasis added.)

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

Comment: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

Response: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will **not** be eligible for capital disproportionate share payments.²⁴

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital’s disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.²⁵

²⁴ (Bold and underline emphasis added.)

²⁵ *Id.* at 43452-53.

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (“BBRA”) and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.²⁶ IPPS hospitals are reclassified per BBRA § 401 are often referred to as “§ 401 hospitals.”

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

*A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and ***disproportionate share calculations*** (§ 412.106) as of the effective date of the reclassification.*²⁷

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes.*** In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific

²⁶ BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

²⁷ 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113.* In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106–113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

*We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. **Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify.** As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.²⁸*

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and

²⁸ 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

Services Administration which is available via the ORHP website at [http:// www.nal.usda.gov/orph](http://www.nal.usda.gov/orph) or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.²⁹

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase “the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area”, it would appear that hospitals reclassified from urban to rural were *not* eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b) through (g)** of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.**³⁰

²⁹ *Id.* at 47048.

³⁰ (Bold and underline emphasis added.)

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. *Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS*

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.³¹ Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas (“CBSAs”) and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.³² On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas (“MSAs”) and the new Micropolitan Areas based on Census 2000 data.³³

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB’s new CBSA designations.³⁴ With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

³¹ Pub. L. 108–173

³² 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

³³ *Id.*

³⁴ 69 Fed. Reg. 48916 (Aug. 11, 2004).

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result

of redesignation of an MSA by the Executive Office of Management and Budget.³⁵

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: “A hospital is classified as a ‘disproportionate share hospital’ for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area.”³⁶ As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital’s location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.³⁷

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB’s new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for

³⁵ *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

³⁶ (Emphasis added.)

³⁷ 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.

As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.³⁸

³⁸ 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary³⁹ announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.⁴⁰

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OMB's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.⁴¹

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital

³⁹ of the Department of Health and Human Services.

⁴⁰ 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

⁴¹ *Id.*

reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.⁴²

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.⁴³

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.⁴⁴

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* (“*Toledo*”),⁴⁵ wherein the hospital made the following contentions:

⁴² *Id.*

⁴³ *Id.*

⁴⁴ (Bold emphasis added.)

⁴⁵ 2021 WL 4502052 (D.D.C. 2021).

Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to “take into account” relative costs of capital for various hospital types and areas of location, as subsection (g) requires.⁴⁶

In *Toledo*, U.S. District Court for the District of Columbia (“D.C. District Court”) outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.⁴⁷ The Court also noted how Congress enacted legislation in 1999⁴⁸ allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.⁴⁹ The Court also noted the separate IPPS payment for a hospital’s *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).⁵⁰ The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.⁵¹

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants’ Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.⁵²

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.⁵³ The Court next examined, however, whether the Secretary’s decision to do so was reasonable. The D.C. District Court made the following findings:

⁴⁶ *Id.* at *8 (citations omitted).

⁴⁷ *Id.* at *2.

⁴⁸ 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a “§ 401” hospital.

⁴⁹ *Toledo* at *3.

⁵⁰ *Id.* at *3-4.

⁵¹ *Id.* at *4.

⁵² *Id.* at *5.

⁵³ *Id.* at *6-8.

1. “if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it.”⁵⁴
2. The Secretary’s decision to not provide a capital DSH adjustment was arbitrary because:
 - “The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006.”⁵⁵
 - “[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements.”⁵⁶
 - “The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp.*, 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why ‘added precision’ ‘would not justify the added complication’) (quotation omitted).”⁵⁷
 - “The agency cannot ‘entirely fail[] to consider’ the “relevant data” and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all.”⁵⁸

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because “vacatur of a rule is not an appropriate remedy on review of an adjudication.”⁵⁹ Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants’ eligibility for a capital DSH adjustment.⁶⁰

Providers’ Request for EJR

The Providers state that EJR is appropriate because the they are challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).⁶¹

The Providers are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent

⁵⁴ *Id.* at *11.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at *11-12.

⁵⁹ *Id.* at *12.

⁶⁰ *Id.*

⁶¹ Request for EJR at 2.

with 42 U.S.C. § 1395ww(d)(8)(E) which states that hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1395ww(d)].” The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(E) and 1395ww(g), and the regulation must be found invalid.⁶² Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.

Since the Board is bound by the regulations being challenged,⁶³ namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers’ Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.

Board Decision

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

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,⁶⁴ the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.⁶⁵ The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider’s cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement (“NPR”) issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the “claim-specific dissatisfaction requirement”). As all of the participants in this case have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

⁶² *Id.* at 3.

⁶³ *See* 42 C.F.R. § 405.1867.

⁶⁴ 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

⁶⁵ *Id.* at 70555.

The participants that comprise this CIRP group appeal have filed appeals involving fiscal years ending June 30, 2018. Both Providers have appealed from original NPRs. Based on its review of the record, the Board finds that both participants in this CIRP group filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the \$50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j), specifies that, in order for a specific item to be eligible for potential reimbursement, the provider must include an appropriate cost report claim for that specific item:

(j) Substantive reimbursement requirement of an appropriate cost report claim—

(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—

(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.

(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) addresses when the Board must examine a provider's compliance with § 413.24(j):

- (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.⁶⁶**

These regulations are applicable to the cost reporting periods under appeal for both of the participants in this group, which both have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"⁶⁷ with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) **if** a party to the appeal questions whether there was an appropriate claim made.⁶⁸ In this CIRP

⁶⁶ (Bold emphasis added.)

⁶⁷ 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

⁶⁸ See 42 C.F.R. § 405.1873(a).

group case, the Medicare Contractor has failed to file a Substantive Claim Challenge⁶⁹ consistent with § 405.1873(a) within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers in the case.⁷⁰

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,⁷¹ the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

The Board also notes that the Medicare Contractor filed a jurisdictional review document after the EJR request was filed noting there are no jurisdictional issues in the case.

C. Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in this group appeal are entitled to a hearing before the Board;
- 2) The Providers' cost reports included appropriate claims for a specific item as required by 42 C.F.R. § 405.1873(a);
- 3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), 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 the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(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

⁶⁹ Board Rule 44.5 states: "The Board adoption 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."

⁷⁰ In this case, the Medicare Contractor filed a response noting that there are no jurisdictional or substantive claim impediments and that EJR is appropriate. Response to Provider's Request for Expedited Judicial Review (Oct. 20, 2022).

⁷¹ The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, 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
Ratina Kelly, CPA

FOR THE BOARD:

11/15/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
Univ. of Rochester CY 2017 Capital DSH CIRP Group
Case No. 22-0416GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (“Board”) has reviewed the Provider’s October 17, 2022 request for expedited judicial review (“EJR”) in the above-referenced common issue related party (“CRIP”) group appeal.¹ The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Providers are

[C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)[²], which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1886(d)].”³

Background

Under the inpatient prospective payment system (“IPPS”), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for

¹ The University of Rochester Medical Center is a health system with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 22-0638GGC for the year 2017. As the health system designated the CIRP group fully formed, it is prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): “When the Board has determined that a group appeal brought under paragraph (b)(1) . . . 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.”

² Codified at 42 U.S.C. § 1395ww(d)(8)(E).

³ Request for Expedited Judicial Review, 3 (Oct. 17, 2022) (“Request for EJR”). See also Issue Statement – Capital DSH.

operating costs (“operating IPPS”) as set forth at § 1395ww(d); and one for capital costs (“capital IPPS”) as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.⁴ This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board (“MGCRB”) which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area⁵ for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.⁶ This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.⁷ Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁸

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.⁹ One of the adjustments is the hospital-specific Disproportionate Share Hospital (“DSH”) adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.¹⁰

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage (“DPP”).¹¹ As a proxy for utilization by low-income

⁴ Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), available at <https://oig.hhs.gov/oas/reports/region1/11700500.pdf> (last visited Oct. 20, 2022) (“*Significant Vulnerabilities*”).

⁵ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html> (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (“CBSAs”) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).

⁶ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). See also *Significant Vulnerabilities* at 4-5.

⁷ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁸ *Id.*

⁹ See 42 U.S.C. § 1395ww(d)(5).

¹⁰ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

¹¹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.¹²

The DSH adjustment provided under operating IPPS is *not* at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.¹³ OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall*, for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .

(B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;*

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

¹² See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

¹³ Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

(C) In this paragraph, the term “capital-related costs” has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.¹⁴

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary “may provide for an adjustment to account variations in relative costs.” As described below, the Secretary exercised his discretion to establish the *capital* DSH adjustment at issue in this case which is limited in that it **only** applies to *urban* hospitals with 100 or more beds and that serve low income patients.¹⁵

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.¹⁶ In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process), we have the latitude to develop adjustments based on combined costs for the capital prospective payment system.*

We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should

¹⁴ (Underline and italics emphasis added.)

¹⁵ 42 C.F.R. § 412.320(a)(1). See also MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).

¹⁶ 56 Fed. Reg. 43356 (Aug. 30, 1991).

reflect only the higher Medicare costs associated with teaching activity and treating low income patients.¹⁷

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $(\{1 + \text{DSHP}\}^{0.4176} - 1)$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.

Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.¹⁸

In adopting his proposal, the Secretary gave the following justification:

Comment: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.

Response: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also

¹⁷ *Id.* at 43369-70 (emphasis added).

¹⁸ *Id.* at 43377.

be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries.**¹⁹

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(1){ii} of the regulations.²⁰

¹⁹ *Id.* at 43409-10 (bold and underline emphasis added).

²⁰ *Id.*

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as “[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high ‘total government’ usage”:

In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.²¹

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.²²

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare’s payment to recognize these higher Medicare patient care costs.²³

²¹ *Id.* at 43378.

²² *Id.* at 43379.

²³ (Emphasis added.)

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

Comment: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

Response: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will **not** be eligible for capital disproportionate share payments.²⁴

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital’s disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.²⁵

²⁴ (Bold and underline emphasis added.)

²⁵ *Id.* at 43452-53.

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (“BBRA”) and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.²⁶ IPPS hospitals are reclassified per BBRA § 401 are often referred to as “§ 401 hospitals.”

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for **all** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

*A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for **all** purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and **disproportionate share calculations** (§ 412.106) as of the effective date of the reclassification.²⁷*

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes.*** In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific

²⁶ BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

²⁷ 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113.* In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106–113, which authorizes a 30-percent expansion in a rural hospital’s resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

*We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. **Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify.** As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.²⁸*

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and

²⁸ 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

Services Administration which is available via the ORHP website at [http:// www.nal.usda.gov/orph](http://www.nal.usda.gov/orph) or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.²⁹

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase “the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area”, it would appear that hospitals reclassified from urban to rural were *not* eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b) through (g)** of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.**³⁰

²⁹ *Id.* at 47048.

³⁰ (Bold and underline emphasis added.)

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. *Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS*

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.³¹ Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas (“CBSAs”) and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.³² On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas (“MSAs”) and the new Micropolitan Areas based on Census 2000 data.³³

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB’s new CBSA designations.³⁴ With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

³¹ Pub. L. 108–173

³² 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

³³ *Id.*

³⁴ 69 Fed. Reg. 48916 (Aug. 11, 2004).

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result

of redesignation of an MSA by the Executive Office of Management and Budget.³⁵

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: “A hospital is classified as a ‘disproportionate share hospital’ for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area.”³⁶ As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital’s location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.³⁷

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB’s new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for

³⁵ *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

³⁶ (Emphasis added.)

³⁷ 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.

As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.³⁸

³⁸ 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).

4. *August 18, 2006 Revisions to the Capital DSH Adjustment*

In the FY 2007 Proposed IPPS Rule, the Secretary³⁹ announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.⁴⁰

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OMB's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.⁴¹

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of

³⁹ of the Department of Health and Human Services.

⁴⁰ 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

⁴¹ *Id.*

the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.⁴²

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.⁴³

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.⁴⁴

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* (“*Toledo*”),⁴⁵ wherein the hospital made the following contentions:

⁴² *Id.*

⁴³ *Id.*

⁴⁴ (Bold emphasis added.)

⁴⁵ 2021 WL 4502052 (D.D.C. 2021).

Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to “take into account” relative costs of capital for various hospital types and areas of location, as subsection (g) requires.⁴⁶

In *Toledo*, U.S. District Court for the District of Columbia (“D.C. District Court”) outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.⁴⁷ The Court also noted how Congress enacted legislation in 1999⁴⁸ allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.⁴⁹ The Court also noted the separate IPPS payment for a hospital’s *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).⁵⁰ The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.⁵¹

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants’ Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.⁵²

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.⁵³ The Court next examined, however, whether the Secretary’s decision to do so was reasonable. The D.C. District Court made the following findings:

⁴⁶ *Id.* at *8 (citations omitted).

⁴⁷ *Id.* at *2.

⁴⁸ 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a “§ 401” hospital.

⁴⁹ *Toledo* at *3.

⁵⁰ *Id.* at *3-4.

⁵¹ *Id.* at *4.

⁵² *Id.* at *5.

⁵³ *Id.* at *6-8.

1. “if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it.”⁵⁴
2. The Secretary’s decision to not provide a capital DSH adjustment was arbitrary because:
 - “The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006.”⁵⁵
 - “[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements.”⁵⁶
 - “The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp.*, 797 F.3d at 1161 (upholding Secretary’s regulation where the Secretary explained why ‘added precision’ ‘would not justify the added complication’) (quotation omitted).”⁵⁷
 - “The agency cannot ‘entirely fail[] to consider’ the “relevant data” and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all.”⁵⁸

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because “vacatur of a rule is not an appropriate remedy on review of an adjudication.”⁵⁹ Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants’ eligibility for a capital DSH adjustment.⁶⁰

Providers’ Request for EJR

The Providers state that EJR is appropriate because the they are challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).⁶¹

The Providers are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent

⁵⁴ *Id.* at *11.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at *11-12.

⁵⁹ *Id.* at *12.

⁶⁰ *Id.*

⁶¹ Request for EJR at 2.

with 42 U.S.C. § 1395ww(d)(8)(E) which states that hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1395ww(d)].” The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(E) and 1395ww(g), and the regulation must be found invalid.⁶² Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.

Since the Board is bound by the regulations being challenged,⁶³ namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers’ Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.

Board Decision

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

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,⁶⁴ the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.⁶⁵ The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider’s cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement (“NPR”) issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the “claim-specific dissatisfaction

⁶² *Id.* at 3.

⁶³ *See* 42 C.F.R. § 405.1867.

⁶⁴ 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

⁶⁵ *Id.* at 70555.

requirement”). As all of the participants in this case have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The participants that comprise this CIRP group appeal have filed appeals involving fiscal years ending June 30, 2017. One Provider has appealed from an original NPR and one Provider has appealed from a revised NPR. For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant’s appeal of matters that the Medicare contractor specifically revised within the revised NPR.⁶⁶ The Board notes that the Provider’s revised NPR appeal included within this EJR request was issued after August 21, 2008. The Provider which filed an appeal from revised NPR removed Capital DSH payments, as required for jurisdiction under the provisions of 42 C.F.R. § 405.1889.⁶⁷

Based on its review of the record, the Board finds that both participants in this CIRP group filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the \$50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

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

(j) Substantive reimbursement requirement of an appropriate cost report claim—

(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—

(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

⁶⁶ See 42 C.F.R. § 405.1889(b)(1) (2008).

⁶⁷ The Board again notes that the prior claim-specific dissatisfaction requirement is no longer applicable. As a result, the fact that the Provider both requested the reopening and adjustment at issue is not relevant. Only the requirement in 42 C.F.R. § 405.1889(b) that the revised NPR at issue specifically adjust the issue/item being appealed is relevant.

(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.

(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) addresses when the Board must examine a provider's compliance with § 413.24(j):

(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.**⁶⁸

These regulations are applicable to the cost reporting periods under appeal for all of the participants in this group, which all have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must

⁶⁸ (Bold emphasis added.)

review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"⁶⁹ with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) *if* a party to the appeal questions whether there was an appropriate claim made.⁷⁰ In this CIRP group case, the Medicare Contractor has failed to file a Substantive Claim Challenge⁷¹ within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers in the case.⁷²

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,⁷³ the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

The Board also notes that the Medicare Contractor filed a response to the EJR request on October 20, 2022 noting there are no jurisdictional or substantive claim issues and that it concurs that EJR is appropriate.

C. Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in this group appeal are entitled to a hearing before the Board;
- 2) The Providers' cost reports included appropriate claims for a specific item as required by 42 C.F.R. § 405.1873(a);
- 3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

⁶⁹ 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

⁷⁰ See 42 C.F.R. § 405.1873(a).

⁷¹ Board Rule 44.5 states: "The Board adoption 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."

⁷² In this case, the Medicare Contractor filed a response noting that there are no jurisdictional or substantive claim impediments and that EJR is appropriate. Response to Provider's Request for Expedited Judicial Review (Oct. 20, 2022).

⁷³ The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

- 4) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 5) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(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. Since this is the only issue under dispute in this case, 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
Ratina Kelly, CPA

FOR THE BOARD:

11/15/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
Albany Medical Center CY 2017 Capital DSH CIRP Group
Case No. 22-0638GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (“Board”) has reviewed the Provider’s October 17, 2022 request for expedited judicial review (“EJR”) in the above-referenced common issue related party (“CIRP”) group appeal.¹ The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Providers are

[C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)[²], which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1886(d)].”³

Background

Under the inpatient prospective payment system (“IPPS”), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for

¹ Albany Medical Center is a health system with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 22-0638GGC for the year 2017. As the Albany Medical Center designated the CIRP group fully formed, the health system is prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): “When the Board has determined that a group appeal brought under paragraph (b)(1) . . . 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.”

² Codified at 42 U.S.C. § 1395ww(d)(8)(E).

³ Request for Expedited Judicial Review at 3 (Oct. 17, 2022) (“EJR Request”). *See also* Issue Statement – Capital DSH.

operating costs (“operating IPPS”) as set forth at § 1395ww(d); and one for capital costs (“capital IPPS”) as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.⁴ This case focuses on the capital IPPS.

A. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board (“MGCRB”) which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area⁵ for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.⁶ This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

B. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.⁷ Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁸

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.⁹ One of the adjustments is the hospital-specific Disproportionate Share Hospital (“DSH”) adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.¹⁰

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage (“DPP”).¹¹ As a proxy for utilization by low-income

⁴ Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), available at <https://oig.hhs.gov/oas/reports/region1/11700500.pdf> (last visited Oct. 20, 2022) (“*Significant Vulnerabilities*”).

⁵ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html> (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (“CBSAs”) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).

⁶ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). See also *Significant Vulnerabilities* at 4-5.

⁷ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁸ *Id.*

⁹ See 42 U.S.C. § 1395ww(d)(5).

¹⁰ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

¹¹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.¹²

The DSH adjustment provided under operating IPPS is *not* at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

C. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.¹³ OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall*, for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .

(B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;*

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

¹² See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

¹³ Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

(C) In this paragraph, the term “capital-related costs” has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.¹⁴

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary “may provide for an adjustment to account variations in relative costs.” As described below, the Secretary exercised his discretion to establish the *capital* DSH adjustment at issue in this case which is limited in that it **only** applies to *urban* hospitals with 100 or more beds and that serve low income patients.¹⁵

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.¹⁶ In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process), we have the latitude to develop adjustments based on combined costs for the capital prospective payment system.*

We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should

¹⁴ (Underline and italics emphasis added.)

¹⁵ 42 C.F.R. § 412.320(a)(1). See also MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).

¹⁶ 56 Fed. Reg. 43356 (Aug. 30, 1991).

reflect only the higher Medicare costs associated with teaching activity and treating low income patients.¹⁷

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $(\{1 + \text{DSHP}\}^{0.4176} - 1)$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.

Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.¹⁸

In adopting his proposal, the Secretary gave the following justification:

Comment: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.

Response: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also

¹⁷ *Id.* at 43369-70 (emphasis added).

¹⁸ *Id.* at 43377.

be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries.**¹⁹

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(1){ii} of the regulations.²⁰

¹⁹ *Id.* at 43409-10 (bold and underline emphasis added).

²⁰ *Id.*

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as “[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high ‘total government’ usage”:

In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.²¹

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.²²

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare’s payment to recognize these higher Medicare patient care costs.²³

²¹ *Id.* at 43378.

²² *Id.* at 43379.

²³ (Emphasis added.)

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

Comment: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

Response: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will **not** be eligible for capital disproportionate share payments.²⁴

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital’s disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.²⁵

²⁴ (Bold and underline emphasis added.)

²⁵ *Id.* at 43452-53.

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (“BBRA”) and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.²⁶ IPPS hospitals are reclassified per BBRA § 401 are often referred to as “§ 401 hospitals.”

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for all purposes under operating IPPS, including the DSH adjustment for operating IPPS:

*A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and disproportionate share calculations (§ 412.106) as of the effective date of the reclassification.*²⁷

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes.*** In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific

²⁶ BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

²⁷ 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113.* In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106–113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

*We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. **Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify.** As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.²⁸*

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and

²⁸ 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

Services Administration which is available via the ORHP website at [http:// www.nal.usda.gov/orph](http://www.nal.usda.gov/orph) or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.²⁹

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase “the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area”, it would appear that hospitals reclassified from urban to rural were *not* eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b) through (g)** of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.**³⁰

²⁹ *Id.* at 47048.

³⁰ (Bold and underline emphasis added.)

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. *Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS*

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.³¹ Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas (“CBSAs”) and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.³² On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas (“MSAs”) and the new Micropolitan Areas based on Census 2000 data.³³

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB’s new CBSA designations.³⁴ With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

³¹ Pub. L. 108–173

³² 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

³³ *Id.*

³⁴ 69 Fed. Reg. 48916 (Aug. 11, 2004).

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result

of redesignation of an MSA by the Executive Office of Management and Budget.³⁵

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: “A hospital is classified as a ‘disproportionate share hospital’ for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area.”³⁶ As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital’s location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.³⁷

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB’s new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for

³⁵ *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

³⁶ (Emphasis added.)

³⁷ 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.

As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.³⁸

³⁸ 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary³⁹ announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.⁴⁰

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OMB's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.⁴¹

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital

³⁹ of the Department of Health and Human Services.

⁴⁰ 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

⁴¹ *Id.*

reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.⁴²

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.⁴³

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.⁴⁴

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* (“*Toledo*”),⁴⁵ wherein the hospital made the following contentions:

⁴² *Id.*

⁴³ *Id.*

⁴⁴ (Bold emphasis added.)

⁴⁵ 2021 WL 4502052 (D.D.C. 2021).

Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to “take into account” relative costs of capital for various hospital types and areas of location, as subsection (g) requires.⁴⁶

In *Toledo*, U.S. District Court for the District of Columbia (“D.C. District Court”) outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.⁴⁷ The Court also noted how Congress enacted legislation in 1999⁴⁸ allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.⁴⁹ The Court also noted the separate IPPS payment for a hospital’s *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).⁵⁰ The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.⁵¹

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants’ Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.⁵²

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.⁵³ The Court next examined, however, whether the Secretary’s decision to do so was reasonable. The D.C. District Court made the following findings:

⁴⁶ *Id.* at *8 (citations omitted).

⁴⁷ *Id.* at *2.

⁴⁸ 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a “§ 401” hospital.

⁴⁹ *Toledo* at *3.

⁵⁰ *Id.* at *3-4.

⁵¹ *Id.* at *4.

⁵² *Id.* at *5.

⁵³ *Id.* at *6-8.

1. “if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it.”⁵⁴
2. The Secretary’s decision to not provide a capital DSH adjustment was arbitrary because:
 - “The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006.”⁵⁵
 - “[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements.”⁵⁶
 - “The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp.*, 797 F.3d at 1161 (upholding Secretary’s regulation where the Secretary explained why ‘added precision’ ‘would not justify the added complication’) (quotation omitted).”⁵⁷
 - “The agency cannot ‘entirely fail[] to consider’ the “relevant data” and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all.”⁵⁸

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because “vacatur of a rule is not an appropriate remedy on review of an adjudication.”⁵⁹ Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants’ eligibility for a capital DSH adjustment.⁶⁰

Providers’ Request for EJR

The Providers state that EJR is appropriate because the they are challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).⁶¹

The Providers are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent

⁵⁴ *Id.* at *11.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at *11-12.

⁵⁹ *Id.* at *12.

⁶⁰ *Id.*

⁶¹ Request for EJR at 2.

with 42 U.S.C. § 1395ww(d)(8)(E) which states that hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1395ww(d)].” The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(E) and 1395ww(g), and the regulation must be found invalid.⁶² Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.

Since the Board is bound by the regulations being challenged,⁶³ namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers’ Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.

Board Decision

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

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,⁶⁴ the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.⁶⁵ The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider’s cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement (“NPR”) issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the “claim-specific dissatisfaction requirement”). As all of the participants in this case have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

⁶² *Id.* at 3.

⁶³ *See* 42 C.F.R. § 405.1867.

⁶⁴ 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

⁶⁵ *Id.* at 70555.

The participants that comprise this CIRP group appeal have filed appeals involving fiscal years ending December 31, 2017. One Provider has appealed from an original NPR and one Provider has appealed from a revised NPR. For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.⁶⁶ The Board notes that the Provider's revised NPR appeal included within this EJR request was issued after August 21, 2008. The Provider which filed an appeal from revised NPR removed Capital DSH payments, as required for jurisdiction under the provisions of 42 C.F.R. § 405.1889.⁶⁷

Based on its review of the record, the Board finds that both participants in this CIRP group filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the \$50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j), specifies that, in order for a specific item to be eligible for potential reimbursement, the provider must include an appropriate cost report claim for that specific item:

(j) Substantive reimbursement requirement of an appropriate cost report claim—

(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—

(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

⁶⁶ See 42 C.F.R. § 405.1889(b)(1) (2008).

⁶⁷ The Board again notes that the prior claim-specific dissatisfaction requirement is no longer applicable. As a result, the fact that the Provider both requested the reopening and adjustment at issue is not relevant. Only the requirement in 42 C.F.R. § 405.1889(b) that the revised NPR at issue specifically adjust the issue/item being appealed is relevant.

(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.

(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) addresses when the Board must examine a provider's compliance with § 413.24(j):

(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.**⁶⁸

These regulations are applicable to the cost reporting periods under appeal for both of the participants in this group, which both have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact*

⁶⁸ (Bold emphasis added.)

and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"⁶⁹ with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) *if* a party to the appeal questions whether there was an appropriate claim made.⁷⁰ In this CIRP group case, the Medicare Contractor has failed to file a Substantive Claim Challenge⁷¹ consistent with § 405.1873(a) within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers in the case.⁷²

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,⁷³ the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

The Board also notes that the Medicare Contractor filed a jurisdictional review letter on August 25, 2022, after the group was fully formed, noting there are no jurisdictional issues in the case.

C. Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in this group appeal are entitled to a hearing before the Board;
- 2) The Providers' cost reports included appropriate claims for a specific item as required by 42 C.F.R. § 405.1873(a);
- 3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), 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

⁶⁹ 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

⁷⁰ See 42 C.F.R. § 405.1873(a).

⁷¹ Board Rule 44.5 states: "The Board adoption 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."

⁷² In this case, the Medicare Contractor filed a response noting that there are no jurisdictional or substantive claim impediments and that EJR is appropriate. Response to Provider's Request for Expedited Judicial Review (Oct. 20, 2022).

⁷³ The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

- 5) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(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. Since this is the only issue under dispute in this case, 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
Ratina Kelly, CPA

FOR THE BOARD:

11/15/2022

 Clayton J. Nix

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

Enclosure: Schedule of Providers

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: *Expedited Judicial Review Determination*
Albany Medical Center CY 2018 Capital DSH CIRP Group
Case No. 21-1661GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (“Board”) has reviewed the Provider’s October 17, 2022 request for expedited judicial review (“EJR”) in the above-referenced common issue related party (“CIRP”) group appeal.¹ The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Providers are:

[C]hallenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for Capital [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider Group contends that] [t]his regulation is inconsistent with Social Security Act Section 1886(d)(8)(E)², which specifically concerns rural status. Section 1886(d)(8)(E) specifically notes that the hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1886(d)].”³

Background

Under the inpatient prospective payment system (“IPPS”), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for

¹ Albany Medical Center is a health system with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 21-1661GC for the year 2017. As the Albany Medical Center designated the CIRP group fully formed, the health system is prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): “When the Board has determined that a group appeal brought under paragraph (b)(1) . . . 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.”

² Codified at 42 U.S.C. § 1395ww(d)(8)(E).

³ Request for Expedited Judicial Review at 3 (Oct. 17, 2022) (“EJR Request”). *See also* Issue Statement – Capital DSH.

operating costs (“operating IPPS”) as set forth at § 1395ww(d); and one for capital costs (“capital IPPS”) as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.⁴ This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board (“MGCRB”) which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area⁵ for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.⁶ This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.⁷ Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁸

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.⁹ One of the adjustments is the hospital-specific Disproportionate Share Hospital (“DSH”) adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.¹⁰

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage (“DPP”).¹¹ As a proxy for utilization by low-income

⁴ Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), available at <https://oig.hhs.gov/oas/reports/region1/11700500.pdf> (last visited Oct. 20, 2022) (“*Significant Vulnerabilities*”).

⁵ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html> (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts “for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.” This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (“CBSAs”) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).

⁶ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). See also *Significant Vulnerabilities* at 4-5.

⁷ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁸ *Id.*

⁹ See 42 U.S.C. § 1395ww(d)(5).

¹⁰ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

¹¹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.¹²

The DSH adjustment provided under operating IPPS is *not* at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment that the Secretary adopted for purposes of capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.¹³ OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

(g) Prospective payment for capital-related costs; return on equity capital for hospitals

(1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall*, for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .

(B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

(ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;*

(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

¹² See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

¹³ Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

(C) In this paragraph, the term “capital-related costs” has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.¹⁴

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary “may provide for an adjustment to account variations in relative costs.” As described below, the Secretary exercised his discretion to establish the *capital* DSH adjustment at issue in this case which is limited in that it **only** applies to *urban* hospitals with 100 or more beds and that serve low income patients.¹⁵

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.¹⁶ In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process), we have the latitude to develop adjustments based on combined costs for the capital prospective payment system.*

We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should

¹⁴ (Underline and italics emphasis added.)

¹⁵ 42 C.F.R. § 412.320(a)(1). See also MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), available at https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).

¹⁶ 56 Fed. Reg. 43356 (Aug. 30, 1991).

reflect only the higher Medicare costs associated with teaching activity and treating low income patients.¹⁷

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $(\{1 + \text{DSHP}\}^{0.4176} - 1)$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.

Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.¹⁸

In adopting his proposal, the Secretary gave the following justification:

Comment: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.

Response: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also

¹⁷ *Id.* at 43369-70 (emphasis added).

¹⁸ *Id.* at 43377.

be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries.**¹⁹

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(1){ii} of the regulations.²⁰

¹⁹ *Id.* at 43409-10 (bold and underline emphasis added).

²⁰ *Id.*

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as “[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high ‘total government’ usage”:

In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.²¹

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.²²

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare’s payment to recognize these higher Medicare patient care costs.²³

²¹ *Id.* at 43378.

²² *Id.* at 43379.

²³ (Emphasis added.)

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

Comment: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

Response: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will **not** be eligible for capital disproportionate share payments.²⁴

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital’s disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.²⁵

²⁴ (Bold and underline emphasis added.)

²⁵ *Id.* at 43452-53.

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (“BBRA”) and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.²⁶ IPPS hospitals are reclassified per BBRA § 401 are often referred to as “§ 401 hospitals.”

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for **all** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

*A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, is treated as rural for **all** purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and **disproportionate share calculations** (§ 412.106) as of the effective date of the reclassification.*²⁷

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes.*** In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific

²⁶ BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

²⁷ 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113.* In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106–113, which authorizes a 30-percent expansion in a rural hospital’s resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

*We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary. **Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify.** As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.²⁸*

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and

²⁸ 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

Services Administration which is available via the ORHP website at <http://www.nal.usda.gov/orph> or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.²⁹

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase “the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area”, it would appear that hospitals reclassified from urban to rural were *not* eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

(2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b) through (g)** of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.**³⁰

²⁹ *Id.* at 47048.

³⁰ (Bold and underline emphasis added.)

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. *Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS*

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.³¹ Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas (“CBSAs”) and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.³² On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas (“MSAs”) and the new Micropolitan Areas based on Census 2000 data.³³

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB’s new CBSA designations.³⁴ With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

³¹ Pub. L. 108–173

³² 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

³³ *Id.*

³⁴ 69 Fed. Reg. 48916 (Aug. 11, 2004).

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result

of redesignation of an MSA by the Executive Office of Management and Budget.³⁵

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: “A hospital is classified as a ‘disproportionate share hospital’ for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area.”³⁶ As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital’s location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.³⁷

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB’s new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for

³⁵ *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

³⁶ (Emphasis added.)

³⁷ 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.

As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.³⁸

³⁸ 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004) (italics emphasis added).

4. *August 18, 2006 Revisions to the Capital DSH Adjustment*

In the FY 2007 Proposed IPPS Rule, the Secretary³⁹ announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.⁴⁰

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OMB's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.⁴¹

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.

These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital

³⁹ of the Department of Health and Human Services.

⁴⁰ 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

⁴¹ *Id.*

reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.⁴²

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.⁴³

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

(a) *Criteria for classification.* A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.⁴⁴

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* (“*Toledo*”),⁴⁵ wherein the hospital made the following contentions:

⁴² *Id.*

⁴³ *Id.*

⁴⁴ (Bold emphasis added.)

⁴⁵ 2021 WL 4502052 (D.D.C. 2021).

Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to “take into account” relative costs of capital for various hospital types and areas of location, as subsection (g) requires.⁴⁶

In *Toledo*, U.S. District Court for the District of Columbia (“D.C. District Court”) outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.⁴⁷ The Court also noted how Congress enacted legislation in 1999⁴⁸ allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.⁴⁹ The Court also noted the separate IPPS payment for a hospital’s *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).⁵⁰ The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.⁵¹

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants’ Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.⁵²

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.⁵³ The Court next examined, however, whether the Secretary’s decision to do so was reasonable. The D.C. District Court made the following findings:

⁴⁶ *Id.* at *8 (citations omitted).

⁴⁷ *Id.* at *2.

⁴⁸ 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a “§ 401” hospital.

⁴⁹ *Toledo* at *3.

⁵⁰ *Id.* at *3-4.

⁵¹ *Id.* at *4.

⁵² *Id.* at *5.

⁵³ *Id.* at *6-8.

1. “if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it.”⁵⁴
2. The Secretary’s decision to not provide a capital DSH adjustment was arbitrary because:
 - “The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006.”⁵⁵
 - “[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements.”⁵⁶
 - “The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp.*, 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why ‘added precision’ ‘would not justify the added complication’) (quotation omitted).”⁵⁷
 - “The agency cannot ‘entirely fail[] to consider’ the “relevant data” and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all.”⁵⁸

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because “vacatur of a rule is not an appropriate remedy on review of an adjudication.”⁵⁹ Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants’ eligibility for a capital DSH adjustment.⁶⁰

Providers’ Request for EJR

The Providers state that EJR is appropriate because the they are challenging the regulation that governs capital DSH payments to urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural).⁶¹

The Providers are challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent

⁵⁴ *Id.* at *11.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at *11-12.

⁵⁹ *Id.* at *12.

⁶⁰ *Id.*

⁶¹ Request for EJR at 2.

with 42 U.S.C. § 1395ww(d)(8)(E) which states that hospitals that have undergone a rural reclassification are rural only for “purposes of this subsection [1395ww(d)].” The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the capital DSH calculation. The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(E) and 1395ww(g), and the regulation must be found invalid.⁶² Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.

Since the Board is bound by the regulations being challenged,⁶³ namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers’ Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.

Board Decision

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

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,⁶⁴ the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.⁶⁵ The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider’s cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement (“NPR”) issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the “claim-specific dissatisfaction requirement”). As all of the participants in this case have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

⁶² *Id.* at 3.

⁶³ *See* 42 C.F.R. § 405.1867.

⁶⁴ 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

⁶⁵ *Id.* at 70555.

The participants that comprise this CIRP group appeal have filed appeals involving fiscal years ending December 31, 2018. Two Providers have appealed from an original NPR and one Provider has appealed from a revised NPR. For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.⁶⁶ The Board notes that the Provider's revised NPR appeal included within this EJR request was issued after August 21, 2008. The Provider which filed an appeal from revised NPR removed Capital DSH payments, as required for jurisdiction under the provisions of 42 C.F.R. § 405.1889.⁶⁷

Based on its review of the record, the Board finds that all three participants in this CIRP group filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the \$50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j), specifies that, in order for a specific item to be eligible for potential reimbursement, the provider must include an appropriate cost report claim for that specific item:

(j) Substantive reimbursement requirement of an appropriate cost report claim—

(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—

(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

⁶⁶ See 42 C.F.R. § 405.1889(b)(1) (2008).

⁶⁷ The Board again notes that the prior claim-specific dissatisfaction requirement is no longer applicable. As a result, the fact that the Provider both requested the reopening and adjustment at issue is not relevant. Only the requirement in 42 C.F.R. § 405.1889(b) that the revised NPR at issue specifically adjust the issue/item being appealed is relevant.

(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.

(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) addresses when the Board must examine a provider's compliance with § 413.24(j):

(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.**⁶⁸

These regulations are applicable to the cost reporting periods under appeal for both of the participants in this group, which both have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact

⁶⁸ (Bold emphasis added.)

and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

This group was fully formed and the participants were fully populated in OH CDMS as of September 7, 2022, and the EJ Request was received on October 17. Since the EJ Request was filed less than sixty (60) days prior to the final schedule of providers in this case being certified,⁶⁹ Board Rule 44.6 (Nov. 2021) applies to Substantive Claim challenges. It reads:

If the final schedule of providers for a group appeal is filed concurrently with an EJ request, or 60 days has not yet transpired between the filing of the final SOP and the EJ request, then the Medicare contractor (or any other moving party) has five (5) business days to either:

1. File any jurisdictional and/or Substantive Claim Challenge(s) related to the group appeal (or participants therein, as relevant); or
2. **Submit a filing wherein the Medicare contractor certifies that it will, *in fact*, be filing a challenge(s)** (whether to a Jurisdictional or Substantive Claim Challenge) related to the group appeal (or participants therein, as relevant) **but it has not yet had an opportunity to complete its review of the final schedule of providers and to finalize the filing for the challenge(s).**

If the Medicare contractor files the certification described above in No. 2, then the Medicare contractor must file the challenge(s) ***no later than twenty (20) days following the filing of the EJ request.*** Following receipt of those challenges (and consistent with 42 C.F.R. §§ 405.1842(e)(3), 405.1873(b)(1), and 405.1873(d)(2) and Board Rule 42.1), the Board will issue a Scheduling Order setting a deadline for the Provider's response and will confirm therein that the 30-day period for the Board to rule on the EJ request has been stayed because the EJ request is incomplete and the Board does not yet have all the information necessary to rule on the EJ request. NOTE: If the Medicare contractor files the certification, then the failure of the Medicare contractor to file any challenges within the 20-day deadline will be grounds for the Board to take remedial action pursuant to 42 C.F.R. § 405.1868(c)(1), unless the Medicare contractor establishes good cause.

Since the EJ Request was filed on Monday, October 17, any certification that a Substantive Claim Challenge was forthcoming would be due no later than close of business Monday, October 24. Likewise, any actual Substantive Claim Challenges would have been due to the Board no later than November 7, 2022.

On October 25, the Medicare Contractor filed a response to the EJ Request which stated, in its entirety:

⁶⁹ Board Rule 20 allows the Provider Representative to file a certification in lieu of a hard copy Final Schedule of Providers if "***all*** the participants in a fully-formed group are ***populated*** . . . in OH CDMS"

Responding to Providers' October 17, 2022, request for expedited judicial review, the MAC notes no jurisdictional impediments. The MAC will, however, be filing a substantive claim challenge in this case.

Rule 44.6 requires the Substantive Claim Challenges to actually be filed within five (5) business days, **or**, within the same time frame a party may merely certify its intent to file a challenge "*but it has not yet had an opportunity to complete its review of the final schedule of providers and to finalize the filing.*"⁷⁰ In this case, the Medicare Contractor's certification was filed one (1) day late and makes no mention of the fact that it could not complete its review of the three (3) providers in this case within five (5) business days. The Board also notes that, as of the date of this decision, the Medicare Contractor has failed to either (1) file a Substantive Claim Challenge, or (2) notify the Board that, despite its certification, no challenge would be filed in this case.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"⁷¹ with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) **if** a party to the appeal questions whether there was an appropriate claim made.⁷² In this CIRP group case, the Medicare Contractor has failed to file a Substantive Claim Challenge⁷³ consistent with § 405.1873(a) within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers in the case.⁷⁴

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,⁷⁵ the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

⁷⁰ (Emphasis added.)

⁷¹ 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

⁷² See 42 C.F.R. § 405.1873(a).

⁷³ Board Rule 44.5 states: "The Board adoption 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."

⁷⁴ In this case, the Medicare Contractor filed a response noting that there are no jurisdictional or substantive claim impediments and that EJR is appropriate. Response to Provider's Request for Expedited Judicial Review (Oct. 20, 2022).

⁷⁵ The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

- 2) The Providers' cost reports included appropriate claims for a specific item as required by 42 C.F.R. § 405.1873(a);
- 3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), 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 the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(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. Since this is the only issue under dispute in this case, 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
Ratina Kelly, CPA

FOR THE BOARD:

11/16/2022

 Clayton J. Nix

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

Enclosure: Schedule 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 21244-1850
410-786-2671

Via Electronic Delivery

Mary Jo Mackniskas
Director of Reimbursement
Alexian Brothers Health System
1000 Remington Blvd.
Bolingbrook, IL 60440

RE: ***Notice of Dismissal***

Alexian Brothers Medical Center (Prov. No. 14-0258)
FYE 06/30/2012, 06/30/2013, 06/30/2014
Case Nos. 15-2543, 16-1299, 17-1165

The Provider Reimbursement Board (“Board” or “PRRB”) has reviewed the Medicare Administrative Contractor’s (“MAC’s”) October 12, 2022 request to dismiss these three above-referenced cases on the ground that the Provider’s representative indicated via communication to the Board on September 28, 2022, that it was going to withdraw these appeals, and has not yet done so.

Effective November 1, 2021, all filings must be submitted electronically using the Office of Hearings Case and Document Management System (“OH CDMS”).¹ This includes the filing of withdraw requests pursuant to Board Rule 46, which references the electronic filing requirement in Board Rule 2. Further, Board Rule 46 provides that “it is the provider’s responsibility to promptly file requests to withdraw a “case that the provider no longer intends to pursue.”

On September 28, 2022, the Provider’s representative sent the Board Advisor an email response to email correspondence from the Board Advisor, which requested the status of these three appeals prior to the October 5, 2022 hearing date. The Provider’s representative stated “[t]his appeal is being dropped.” While the email language refers to appeal in the singular, the subject line to the email correspondence specifically lists the three appeal numbers scheduled for hearing on October 5, 2022 to which the correspondence is referring. Further, the second contact person for the Provider who is listed in OH CDMS for Case Nos. 16-1299 and 15-2543, and who was copied on all email correspondence, has not responded or provided any information to indicate

¹ See Board Rule 2.1 (version 3.1). As background, on June 16, 2021, Board Alert 21 and Board Order No. 1 were issued by the Board to give the provider community more than 120 days’ notice of this new requirement:

Effective November 1, 2021, *all submissions* to the Board for new or pending appeals (e.g., appeal requests, correspondence, position papers) *must be filed electronically* using the Office of Hearings Case and Document Management System (“OH CDMS”), unless the Board grants an exemption.

Concurrent with this notice, and effective for any filings made on or after November 1, 2021, the Board published revised Board Rules to implement this new requirement at Board Rule 2.1.1. As explained in Board Rule 2.1.1, OH CDMS is a web-based portal for parties to enter and maintain their cases and to correspond with the Board. Access to a specific case is limited to the parties of that case and the parties’ designated representatives.

she was not in agreement with the email described above. To date, the Provider's representatives have not filed requests to withdraw these three appeals in OH CDMS. Further, the Provider's representatives have not responded to the MAC's motion to dismiss these three cases, and the time for doing so has now passed.²

The Board Rules are clear that all filings, including requests to withdraw, must be filed electronically in OH CDMS. Further, Board Rule 46 requires providers to *promptly* file requests to withdraw cases that the provider no longer intends to pursue. It is clear from the Provider's representative's email that she intended to no longer pursue these three cases and accordingly, to withdraw these cases, but has failed to do so in OH CDMS. For this reason, the Board has a reasonable basis to believe that these cases have been abandoned.

Board Rule 41.2 (v. 3.1, 2021) permits, in pertinent part, dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned, and
- upon failure of the provider or group to comply with Board procedures or filing deadlines (see 42 C.F.R. § 405.1868).

Therefore, pursuant to Board Rule 41.2, the Board dismisses these cases as abandoned, and for the failure of the provider to comply with Board procedures, as described above. Accordingly, these cases will be removed from the Board's docket.

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

Board Members Participating:

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

For the Board:

11/16/2022

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS Government Health Administrators
Wilson C. Leong, FSS

² Board Rule 44.3 provides that the opposing party may file a response to a motion within 30 days from the date that the motion was sent to the Board and the opposing party. In these cases, the Motion to Dismiss was filed on October 12, 2022, and 30 days thereafter was Friday, November 11, which is a government holiday. Therefore, the deadline to respond was extended to Monday, November 14, 2022 pursuant to Board Rule 4.4.3.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Russel Kramer
Quality Reimbursement Services, Inc.
150 N. Santa Anita Ave., Ste. 570A
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Pamela VanArsdale
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Indianapolis, IN 46206

RE: ***Board Decision – SSI Percentage (Provider Specific) and Medicaid Eligible Days***
Metro-East Services Inc. (Prov. No. 14-0307)
FYE 12/31/2018
Case No. 21-1723

Dear Mr. Kramer and Ms. VanArsdale:

The Provider Reimbursement Review Board (“PRRB” or “Board”) reviewed the documentation in Case No. 21-1723 in response to a jurisdictional challenge filed by the Medicare Contractor (“MAC”). The Board’s decision is set forth below.

Background:

A. Procedural History for Case No. 21-1723

On September 14, 2021, Metro East Services, Inc., appealed a Notice of Program Reimbursement (“NPR”) dated August 20, 2021, for its fiscal year ending December 31, 2018 (“FY 2018”). The Provider appealed the only the following 2 issues:¹

- **Issue 1** – Disproportionate Share Hospital (DSH) – Supplemental Security Income (SSI) Percentage (Provider Specific)
- **Issue 2** – DSH – Medicaid Eligible Days

On September 1, 2022, the Medicare Contractor filed a Jurisdictional Challenge regarding ***both*** Issues 1 and 2, addressing the DSH Supplemental Security Income (“SSI”) Percentage related issue and the DSH Medicaid Eligible Days issue.² Significantly, the Provider did not file a response to the Jurisdictional Challenge within the 30 days allotted under Board Rule 44.4.3 which specifies: “Providers must file a response within thirty (30) days of the Medicare contractor’s jurisdictional challenge unless the Board establishes a shorter deadline via a

¹ Provider’s Request for Hearing, Issue Statement (Sep. 14, 2021).

² MAC Jurisdictional Challenge, at 1 (Sep 1, 2022).

Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.”

B. Description of Issue 1 in the Appeal Request and the Provider’s Participation in Case No. 21-1724GC

The Provider’s appeal request describes Issue 1 – DSH SSI Percentage (Provider Specific) issue as follows:

The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC’s calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary’s Regulations.

The provider contends that its’ SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider’s cost report by the MAC are both flawed.

The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider’s cost reporting period.³

As the Provider is commonly owned by BJC Healthcare, the Provider was also directly added to the common issue related party (“CIRP”) group under Case No. 21-1724GC entitled “BJC Healthcare CY 2018 DSH SSI Percentage CIRP Group.” This CIRP group has the following issue statement:

Statement of the Issue:

Whether the Secretary properly calculated the Provider’s [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include

³ Provider’s Request for Hearing, Issue Statement (Sep. 14, 2021).

paid/covered/entitled as well as unpaid/con-covered/eligible SSI days?

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA records,
2. Failure to adhere to required notice and comment rulemaking procedures,
3. Fundamental problems in the SSI percentage calculation,
4. Not in agreement with provider's records,
5. Paid days vs. Eligible Days, and
6. Covered days vs. Total days.⁴

The amount in controversy listed for the Provider as a participant in 21-1724GC is \$121,671.

On May 14, 2022, the Provider filed its preliminary position paper. The following is the Provider's *complete* position on Issue 1 set forth therein:

Calculation of the SSI Percentage

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).

The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to

⁴ Group Issue Statement, Case No. 21-1724GC.

analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFATIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 1, which shows that the amount in controversy for the issue is \$121,671. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 21-1724GC.

MAC's Contentions:

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of Issue 2, which was directly filed into Group Case No. 21-1724GC, *BJC Healthcare CY 2018 DSH SSI Percentage CIRP Group*.⁵ The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.⁶

Lastly, the MAC argues that Issue 1 should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.

Issue 2 – DSH Medicaid Eligible Days

The MAC also argues that the Provider has abandoned the DSH – Medicaid Eligible Days issue. Pursuant to Board Rule 25.3, parties should file a complete preliminary position paper with a fully developed narrative, all exhibits, a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853, which the Provider did not do with respect to the Medicaid eligible days issue.⁷

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

Provider’s Response:

The Provider did not file a response to the jurisdictional challenge. As previously noted, Board Rule 44.4.3 which specifies: “Providers must file a response within thirty (30) days of the Medicare contractor’s jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.”

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), 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 (or \$50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Provider Specific

The analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue directly filed into Case No. 21-1724GC, *BJC Healthcare CY 2018 DSH SSI Percentage CIRP Group*.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was directly filed into Case No. 21-1724GC. The first aspect of Issue 1 in the present appeal concerns “whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation.”⁸ The Provider’s legal basis for this aspect of Issue 1 is simply that the Medicare Contractor “did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i).”⁹ Similarly, the Provider argues that “it[s] SSI percentage published by [CMS] was incorrectly computed . . .” and it “. . . [s]pecifically . . . disagrees with the MAC’s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary’s Regulations.”¹⁰ The DSH systemic issues filed into Case No. 21-1724GC, similarly alleges that the Medicare Contractor and CMS improperly

⁸ Individual Appeal Request, Issue 1.

⁹ *Id.*

¹⁰ *Id.*

calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the CIRP group, namely \$121,671.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 21-1724GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6 (Nov. 1, 2021), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not “specific” to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 21-1724GC. Further, any alleged “systemic” issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.¹¹ Provider is misplaced in referring to Issue 1 as “Provider Specific” and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) in its appeal request of how the alleged “provider specific” errors can be distinguished from the alleged “systemic” issue rather than being subsumed into the “systemic” issue appealed in Case No. 21-1724GC.

To this end, the Board also reviewed the Provider’s Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1724GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider’s Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers “to be **fully** developed and include **all available** documentation necessary to provide a *thorough understanding* of the parties’ positions.” Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged “errors” in its Preliminary Position Paper and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

¹¹ The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. See *Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, “[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital’s patients eligible for both SSI and Medicare at the hospital’s request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital’s fiscal year differs from the Federal fiscal year, for the **months included in the 2 Federal fiscal years that encompass the hospital’s cost reporting period.*** Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year.* The data set made available to hospitals will be the **same data set** CMS uses to calculate the Medicare fractions for the Federal fiscal year.” Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services (“CMS”) and in some cases on a self-service basis as explained on the following webpage:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.¹² This CMS webpage describes access to DSH data **from 1998 to 2017** as follows: “DSH is now a self-service application. This **new self-service process** enables you to enter your data request(s) and retrieve your data files through the CMS Portal.”¹³

Accordingly, the Board must find that Issues 1 and the group issue in Group Case 21-1724GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board

¹² (Last accessed Nov. 21, 2022.)

¹³ (Emphasis added.)

dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider’s DSH percentage, “[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request...” Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider’s DSH SSI Percentage realignment as such there is no “determination” to appeal and the appeal of this issue is otherwise premature.

B. DSH Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider states Issue 2 as:

Statement of the Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital (“DSH”) calculation.

Statement of the Legal Basis

The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary’s Regulations.

The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.¹⁴

The amount in controversy calculation and protested item documentation for this issue suggests that there are 197 Medicaid eligible days at issue. However, the Provider’s appeal request did

¹⁴ *Id.*

not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

On May 14, 2022, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.¹⁵ Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case (*e.g.*, whether there remained 197 as suggested in the appeal request or more or less). Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

Calculation of Medicaid Eligible Days

Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).

The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

[T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

¹⁵ Provider's Preliminary Position Paper at 8 (May 14, 2022).

Base on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its jurisdictional challenge, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of \$87,737, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper.

Board Rule 7.3.1.2 (Nov. 2021) states:

No Access to Data

If the Provider elects not to claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.¹⁶

42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

(2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper *must set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue.*

¹⁶ See also Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions.*¹⁷

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Jul. 2015) states:

If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Similarly, with regard to position papers,¹⁸ Board Rule 25.2.1 requires that “the parties must exchange all available documentation as exhibits to fully support your position.”¹⁹ This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.²⁰

When determining a hospital’s Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

¹⁷ (Emphasis added.)

¹⁸ The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. See Board Rule 27.2.

¹⁹ (Emphasis added.)

²⁰ (Emphasis added.)

The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures,
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for *each* Medicaid patient day claimed"²¹ and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support

²¹ (Emphasis added.)

its claims or describe why said evidence is unavailable, which the Provider has failed to do.²² The Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative and, notwithstanding, QRS failed to provide the Medicaid eligible days listing with its preliminary position paper.²³

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 21-1724GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers. The Board also dismisses the Medicaid eligible days issue as the Provider also failed to meet the Board requirements for position papers for this issue. As no issues remain pending, the Board hereby closes Case No. 21-1723 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

11/21/2022

 Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

²² Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

²³ Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by letter dated 5/5/2022); Case No. 16-2521 (by letter dated 5/5/2022); Case No. 16-0054 (by letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by letter dated 9/30/2022). Moreover, the Board's attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor (as a motion or in a position paper) well in advance of the position paper filed in this case.



DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: *Board Decision*

Stormont Vail Hospital (17-0086)
FYE: 9/30/2014
Case Number: 18-0436

Dear Mr. Ravindran and Mr. Lamprecht:

The Provider Reimbursement Review Board (“PRRB” or “Board”) reviewed the documentation in Case No. 18-0436, pursuant to a jurisdictional challenge filed by the Medicare Contractor (“MAC”). The Board’s decision is set forth below.

Background

On December 22, 2017, Stormont appealed a Notice of Program Reimbursement (NPR) dated July 20, 2017, for its fiscal year end (FYE) September 30, 2014 cost reporting period. The Provider filed an appeal for the following issues:¹

- **Issue 1:** Disproportionate Share Hospital (DSH) – Supplemental Security Income (SSI) Percentage (Provider Specific)
- **Issue 2:** DSH – Medicaid Eligible Days

Issue 1 was framed in the provider’s initial appeal as follows:

The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.1 06(b)(2)(i) of the Secretary's Regulations.

The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was

¹ Provider’s Request for Hearing, Tab 3, at Issue Statement (Sep. 14, 2021).

incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. See 42 U.S.C. 1395 (d)(5)(F)(i).²

On March 16, 2018, the provider added two additional issues, Issue 3, Bad Debts, and Issue 4, SSI Percentage (Systemic Errors).

The Medicare Contractor filed a Jurisdictional Challenge on April 12, 2018, regarding Issue 1, addressing the DSH Supplemental Security Income (“SSI”) Percentage related issue.³

MAC’s Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC contends that the Board does not have jurisdiction over the SSI Realignment included within the Provider Specific issue.

The MAC contends that this issue is suitable for reopening, but it is not an appealable issue. The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election, not a MAC determination. The hospital must make a formal request, through its MAC, to CMS in order to receive a realigned SSI percentage. For the respective fiscal year, once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.⁴

While there are disputes with the SSI percentage, the MAC argues, there is a distinction between a provider questioning the underlying validity of its SSI percentage (an appealable issue) and the realignment to its cost reporting period (a provider election). The provider cannot appeal the realignment of its SSI percentage or try to leverage its appeal regarding the validity of the SSI percentage by attempting to include realignment to its own fiscal year in a PRRB appeal before exhausting its available remedy of requesting CMS to recalculate the SSI ratio using their fiscal year end.⁵

² Provider’s Request for Hearing, Tab 3, Issue statement (Dec. 22, 2017).

³ MAC Jurisdictional Challenge, at 1 (Sep 1, 2022).

⁴ *Id.* at 3.

⁵ *Id.* at 4.

Provider's Response

The Provider filed a response to the jurisdictional challenge on May 9, 2018.

The Provider argues that it is not addressing a realignment of the SSI percentage, but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category. Accordingly, this is an appealable item because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2014 resulting from its understated SSI percentage.⁶

The Provider is entitled to appeal an item with which it is dissatisfied. Further, Centers for Medicare and Medicaid Services ("CMS") in *Northeast Hospital Corporation v. Sebelius* (D.C. Cir., Sep. 13, 2011) specifically abandoned the CMS Administrator's December 1, 2008 decision that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS. Accordingly, the Provider believes that it can specifically identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS. Once these patients are identified, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage based on CMS' admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.⁷

Board Analysis and Decision

The Board dismisses Issue No. 1 regarding DSH/SSI Percentage (Provider Specific) issue for the reasons set forth below.

SSI Provider Specific

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is \$10,000 or more (or \$50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

A. First Aspect of Issue 1

The first aspect of Issue No. 1 relates to the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage. This DSH SSI Percentage (Provider Specific) issue in the present appeal concerns:

⁶ Provider's Jurisdictional Response, at 1 (May 9, 2018).

⁷ *Id.*

[T]he MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.⁸

The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.⁹

In the SSI percentage issue directly added to this same case on March 16, 2018, as Issue 4, the Provider asserts that:

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

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA Records;
2. Paid days vs. eligible days;
3. Not in agreement with provider's records;
4. Fundamental problems in the SSI percentage calculation;
5. Covered days vs. Total days; and
6. Failure to adhere to required notice and comment rulemaking procedures.¹⁰

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 4 (the DSH/SSI (Systemic Errors) issue) which was directly filed into this case. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."¹¹ The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42

⁸ Provider's Request for Hearing, Tab 3, at Issue Statement, Issue 1 (Dec. 22, 2017).

⁹ *Id.*

¹⁰ See Provider's Request to Add Issue, Issue 4 (Mar. 16, 2018).

¹¹ Individual Appeal Request, Issue 1.

U.S.C. § 1395ww(d)(5)(F)(i).”¹² Similarly, the Provider argues that “it[s] SSI percentage published by [CMS] was incorrectly computed . . .” and it “. . . [s]pecifically . . . disagrees with the MAC’s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary’s Regulations.”¹³ The DSH systemic issue similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

In making this finding, the Board further notes that CMS’ regulation interpretation for the SSI percentage is clearly not “specific” to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is already pursuing that issue as part of Issue 4, in this same case. Further, any alleged “systemic” issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.¹⁴ The Provider’s reliance upon referring to Issue 1 as “Provider Specific” is misplaced, and the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged “provider specific” errors can be distinguished from the alleged “systemic” issue rather than being subsumed into the “systemic” issue appealed in Issue 4.

Accordingly, the Board finds that Issues 1 and Issue 4 are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

B. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider’s DSH percentage, “[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request. . . .” Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider’s DSH SSI Percentage realignment. Further, it is important to note that the federal fiscal year ends on September 30th, as does the Provider’s cost reporting period, and thus, any realignment of the SSI percentage would have no effect.

As such, Issue 1, the Provider specific issue is dismissed.

Decision

¹² *Id.*

¹³ *Id.*

¹⁴ The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. See *Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

The Board finds that Issue 1 is duplicative of the SSI Systemic errors being pursued in Issue 4, and that there is no final determination from which the Provider can appeal the SSI realignment issue. For these reasons, Issue 1 will be dismissed in its entirety. As there are additional issues pending in the appeal, the case will remain open.

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

Board Members Participating:

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For the Board:

11/22/2022

 Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

cc: Wilson Leong, Federal Specialized Services



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RE: *Closure of Cases & Suspension of Jurisdictional & Substantive Claim Processes*

21-1559G King & Spalding CY 2017 DGME Fellow Penalty Prior and Penultimate Years Group
21-1560G King & Spalding CY 2017 DGME Fellow Penalty Present Year Group

Dear Messrs. Hettich and Leong:

As the parties are aware, King & Spalding, LLP (“King & Spalding”), the Providers’ designated representative, filed a consolidated request for expedited judicial review (“EJR”) on June 30, 2022 for the above-referenced optional group cases on the following issue:

[W]hether the formula for calculating the number of full-time equivalent (“FTE”) residents a hospital may count in a year for the purposes of direct graduate medical education [(“DGME”)] reimbursement, as contained in 42 C.F.R. [§] 413.79(c)(2)(iii), is unlawful because it penalizes hospitals that train “fellows” (*i.e.*, residents who are not in their initial residency period) while operating in excess of their FTE caps.¹

It has come to the Board’s attention that the Providers’ have filed a complaint in federal district court² to pursue the merits of their EJR request, notwithstanding the fact that the Board has not yet completed its jurisdictional review and not yet issued a determination on their EJR request. As set forth in more detail below, the Provider Reimbursement Review Board (“Board”) hereby takes the following actions consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure (“FRCP”) 62.1³:

1. Closes these 2 group cases; and
2. Suspends completion of its jurisdictional and substantive claim review processes.

¹ EJR Request at 1 (June 30, 2022). In addition, for three Providers that admittedly did not self-disallow this issue, those Providers seek to have the self-disallowance regulation at 42 C.F.R. § 413.24(j) declared unlawful. *Id.* at 2.

² *The Univ. of Vermont Med. Ctr. Inc., et al. v. Becerra*, 1:22-cv-2252 (D.D.C. Aug. 1, 2022).

³ FRCP 62.1 is entitled “Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal.” While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looks to it for guidance.

Procedural Background:

On June 30, 2022, King & Spalding initially filed an EJR request for Case Nos. 21-1559G and 21-1560G. On July 7, 2022, Federal Specialized Services (“FSS”) requested sixty (60) additional days to complete its jurisdictional review of the two cases. The Providers did not file any opposition to this request.

By letter dated July 13, 2022, the Board granted an extension of time and issued a Scheduling Order that required the Medicare Contractor and/or FSS to respond to the EJR request on or before August 29, 2022, and the Providers to file their response to that filing on or before September 28, 2022.⁴ The Board also provided Notice of when the 30-day period for responding to the EJR request commenced, explaining that it would not commence until the Board completed its pre-requisite jurisdictional review of these optional groups, and that the Scheduling Order necessarily affected the 30-day period for the Board’s determination of authority required to decide the EJR request.⁵ The Board clarified that it would continue its review of the jurisdiction in these optional group cases, as well as review the Providers’ request for EJR, upon receipt of the requested information, or the September 28, 2022, filing deadline, whichever occurred first.

On August 10, 2022, the Secretary published the Final Rule on Hospital Inpatient Prospective Payment Systems (“IPPS”) for Fiscal Year 2023 in the Federal Register.⁶ The IPPS Final Rule included a new payment formula for DGME costs that will be applied *retroactively*.⁷ Moreover, the Secretary modified the regulation at 42 C.F.R. § 413.79(c)(2)(iii) to state that, effective for cost reporting periods beginning on or after October 1, 2001, if the hospital’s unweighted number of FTE residents exceeds the limit described in the final rule, and the number of weighted FTE residents in accordance with § 413.79(b) also exceeds that limit, the respective primary care and obstetrics and gynecology weighted FTE counts and other weighted FTE counts are adjusted to make the total weighted FTE count equal the limit. If the number of FTE residents weighted in accordance with § 413.79(b) does not exceed that limit, then the allowable weighted FTE count is the actual weighted FTE count. Further, the Secretary made a conforming change to the regulations text at 42 C.F.R. § 413.79(d)(3) regarding application of the 3-year rolling average to state that for cost reporting periods beginning on or after October 1, 2001, the hospital’s weighted FTE counts for the preceding two cost reporting periods are calculated in accordance with the payment formula at § 413.79(c)(2)(iii).

On September 2, 2022, the Board issued a Scheduling Order requiring additional briefing from the parties in the two cases. Specifically, the Board required the parties to supplement their filings related to the EJR request following the publication of the FY 2023 IPPS Final Rule. As a result of this subsequent legal development, the Board exercised its authority under 42 C.F.R.

⁴ The Board notes that in Case No. 21-1560G, on August 25, 2022, FSS filed a substantive claim challenge for three of the Providers, and the Providers filed a response on September 23, 2022.

⁵ The Board’s July 25, 2022 Notice provided a detailed discussion of the basis for this finding based on the application of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 (with particular emphasis on § 405.1842(b)(2) which address “Initiating EJR”).

⁶ 87 Fed. Reg. 48,780 (Aug. 10, 2022).

⁷ *Id.* at 49,065-72.

§ 405.1842(e)(3) to require that the Group Representative provide a case-status update and confirm whether the EJR request has been rendered moot by the FY 2023 IPPS Final Rule or whether the participants in these groups remained committed to pursuing the EJR requests. If the participants remained committed to pursuing the EJR request, then they were to update the EJR request to:

- (i) discuss the impact of the Final Rule on the EJR requests challenging the Secretary’s policy and regulation establishing the payment methodology for determining payments to hospitals for the direct costs of approved DGME programs, specifically the method of calculating DGME payments to teaching hospitals when those hospitals’ weighted FTE counts exceed their FTE cap; and
- (ii) modify the EJR request, as relevant, based on this impact.

The Board’s Scheduling Order also referenced its July 13, 2022 Notice of when the 30-day period to review an EJR request commences, and reaffirmed that this Notice remained in effect as the Board had not yet (and still has not) completed its jurisdictional review.

On September 23, 2022, King & Spalding responded and asserted that:

1. Their EJR request was not moot at that time because the Final Rule takes effect on October 1, 2022 and, as such, the Board continues to lack the authority to grant the relief requested for either of the two issues for which EJR was requested; and
2. Even after the 2023 Final Rule takes effect, the Board will continue to lack the authority to put aside CMS’ self-disallowance regulation.

Further, King & Spalding informed the Board that, previously on August 1, 2022, the Providers had filed a complaint in the U.S. District Court for the District of Columbia seeking judicial review of their appeals pursuant to 42 U.S.C. § 1395oo(f)(1), in order to preserve their right to interest under 42 U.S.C. § 1395oo(f)(2). King & Spalding gave the following explanation of why it filed the Complaint in the federal district court:

As noted above, in order to preserve their right to interest, the Providers filed a complaint on August 1, 2022, which was 31 days after they had filed their EJR request, with all required materials, with the Board. *See* 42 U.S.C. § 1395oo(f)(1) (allowing a provider to file a complaint if it has not received the Board’s EJR decision “within thirty days after the Board receives” the “documents and materials as the Board shall require for purposes of rendering such determination”). **The Providers are aware that the Board is bound by CMS’s regulation which interprets 42 U.S.C. § 1395oo(f)(1) to mean that the thirty-day clock does not begin to run until after the Board has determined that it has jurisdiction over the appeal and that there is no time limit for the Board to determine jurisdiction.** *See* 42 C.F.R. § 405.1842(b)(2). We respectfully disagree with that interpretation of the statute for multiple reasons and have noted our disagreement in our complaint before the court. (Notably, while some other courts have upheld the

agency's regulation in this regard, it has not been addressed by the D.C. Circuit.)

King & Spalding asserts that further proceedings in these cases should be stayed pending the resolution of that Complaint, citing 42 C.F.R. § 405.1842(h)(3)(iii) and 73 Fed. Reg. 30189, 30214-15 (May 23, 2008).

On October 11, 2022, the Providers filed their Preliminary Position Paper ("PPP"). Notwithstanding the Board's September 2, 2022 order directing the Providers to address the impact of the changes in the FY 2023 IPPS Final Rule on their EJR request, the Providers' PPP does ***not*** address the Secretary's modification of the regulatory provision that the Providers are challenging and the new payment formula for DGME costs that will be applied *retroactively*.

On October 12, 2022, the Medicare Contractor filed a Motion to dismiss these cases pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), which bars the Board from conducting any further proceedings once the provider commences action in Federal Court. The Providers had 30 days to respond to the Motion per Board Rule 44.3. However, more than 30 days have passed, and the Providers have failed to respond.

King and Spalding ***filed a Complaint in the U.S. District Court for the District of Columbia regarding the merits of their EJR request as filed in these appeals***, on August 1, 2022.⁸ This is a significant action by the Providers that impacts the Board proceedings because 42 C.F.R. § 405.1842(h)(3) directs the Board to conduct no further proceedings under such circumstances:

(h) Effect of final EJR decisions and lawsuits on further Board proceedings –

(3) Provider lawsuits. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.

(iii) If the lawsuit is filed before a final EJR decision is issued on the legal question, the Board may not conduct any further

⁸ See *supra* note 2 (A copy of the Complaint is attached to the Providers' Response to Scheduling Order filed on Sept. 23, 2022).

proceedings on the legal question or the matter at issue until the lawsuit is resolved.⁹

Accordingly, the filing of this Complaint in Federal District Court made clear that the Providers had abandoned the Board's jurisdictional and substantive claim review processes. In the Complaint, the Group Representative alleges that the Board did not rule on the Providers' requests for EJR within the 30-day timeframe, as required by 42 U.S.C. § 1395oo(f)(1). Based on this allegation, the Plaintiffs in these groups claimed that they had 60 days, after the expiration of the alleged 30-day EJR review timeframe, in which to file a civil action challenging the Board's lack of decision.¹⁰

Board Findings and Ruling:

The Board must decide what effect the Providers' filing of a lawsuit has on the proceedings before the Board in connection with the above-referenced group cases.

A. The 30-day Period for Responding to the EJR Requests Has Not Yet Begun and Bypassing the Completion of that Process Automatically Raises Potential Fraud, Waste and Abuse Concerns.

As discussed in more detail above, the Board's correspondence in these cases notified the parties on multiple occasions, in detail, that the 30-day period for EJR review does not begin until the Board completes its jurisdictional review and finds jurisdiction. Set forth below is a summary of that explanation.

Parties to a Board appeal may request EJR pursuant to the provisions of 42 U.S.C. § 1395oo(f)(1) which states, in relevant part:

Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider ***may file*** a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). ***The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials,*** and the

⁹ (Emphasis added.)

¹⁰ Complaint, ¶ 47.

determination shall be considered a final decision and not subject to review by the Secretary.¹¹

To implement this statutory provision, the Secretary promulgated the regulation at 42 C.F.R. § 405.1842, setting forth the process for obtaining EJR, and the Board's obligations under the statute. As demonstrated by the following excerpts, 42 C.F.R. § 405.1842 makes clear that the 30-day clock for processing an EJR request does not begin until *after* the Board rules on jurisdiction:

(a) *Basis and scope.* (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter** (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).

(2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).

(4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act *only if*—

(i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue** and a determination by the Board that it has no authority to decide the relevant legal question; or

(ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days after finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete.**

(b) *General*—(1) *Prerequisite of Board jurisdiction.* The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question.**

¹¹ (Emphasis added).

(2) *Initiating EJR procedures.* A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal Under paragraphs (d) and (e) of this section, a **provider may request** a determination of the Board's authority to decide a legal question, but **the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act [i.e., 42 U.S.C. § 1395oo(f)(1)] does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete.**¹²

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period “does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider’s request is complete.”¹³ Moreover, the Board is bound by this regulation because, as stated in 42 C.F.R. § 405.1867, “[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act *and regulations issued thereunder*” Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.¹⁴

¹² (Emphasis added).

¹³ 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: “In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(1), ***we would emphasize that a Board finding that it has jurisdiction over the specific matter at issue is a prerequisite for its determination of its authority to decide the legal question,*** and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR ‘[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].’ In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision, that the 30-day time limit specified in section 1878(f)(1) of the Act for the Board to act on a provider's complete request does not begin to run until the Board has found jurisdiction*** on the specific matter at issue.” (emphasis added)).

¹⁴ (Emphasis added.)

Thus, it is clear that the 30-day clock does not start until *after* the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request.¹⁵

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR “*if [it] may obtain a hearing under subsection (a). . .*”¹⁶ Thus, as the Court in *Alexandria Hospital v. Bowen* (“*Alexandria*”)¹⁷ noted, “the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals.”¹⁸ The Court in *Alexandria* continued:

Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal.* The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction.* EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .

The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is without merit.*¹⁹

¹⁵ Note that the Board's use of the term “stay” (as used in this and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

¹⁶ 42 U.S.C. § 1395oo(f)(1) (emphasis added).

¹⁷ *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986) (hereinafter “*Alexandria*”).

¹⁸ *Alexandria* at 1244. See, H.R. Rep. No. 96-1167, reprinted in 1980 U.S. Code Cong. & Ad. News at 5757; See also, *San Francisco General Hosp. v. Shalala*, No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan*, 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen*, Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).

¹⁹ *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

The *Alexandria* Court’s conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board’s jurisdictional requirements, would still be able to prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.²⁰ Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

The above discussion makes it clear that, per the regulations at 42 C.F.R. §§ 405.1842(a)(4)(i) and 405.1842(b)(2), the 30-day EJR review period, specified at 42 U.S.C. § 1395oo(f)(1), does not begin until the Board completes its jurisdictional review process and finds jurisdiction.

B. Status of the Cases and the Board’s Jurisdictional Review

King and Spalding filed its lawsuit in federal district court on August 1, 2022 – before the Board had completed its jurisdictional review to confirm whether it had jurisdiction to hear all of the disputes raised in the providers’ EJR request *and* whether the record was sufficiently developed following the August 10, 2022 Final Rule. Having sufficient time to complete the jurisdictional and substantive claim review²¹ process is important to ensure that the groups, and all the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules. Without a proper jurisdictional review, fraud, waste and abuse concerns could arise. Specifically, absent a proper jurisdictional review, there is a risk of prohibited participation of CIRP providers in optional groups.

As stated above, 42 C.F.R. § 405.1842(h)(3)(iii) specifies that, “[i]f the lawsuit is filed before a final EJR decision is issued on the legal question, *the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved.*”²²

King & Spalding has made clear in its filings before the Board and in Court that it disagrees with the Board’s interpretation of the mandatory jurisdictional requirements in EJR proceedings and the need to resolve any jurisdictional and substantive challenges before ruling on an EJR request. For the cases in which the Board has not yet issued an EJR determination, its lawsuit is based on a contention that the Board failed to process its EJR request within the 30-day period prescribed in 42 U.S.C. § 1395oo(f)(1).

²⁰ It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules.

²¹ As stated in Board Rule 44.5, “[t]he Board adoption 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.”

²² (Emphasis added.)

Significantly, the Board consistently notified the parties that the 30-day period had not begun because the Board had not completed its jurisdictional and substantive claim review. *However, at no point in the proceedings before the Board has King & Spalding referenced or challenged the Board's stated reliance on 42 C.F.R. § 405.1842(b)(2) in issuing that notification or otherwise challenged the validity of that regulation until after it filed its Complaint in federal district court.* In this regard, the Board notes that King & Spalding neither filed opposition to FSS' request for an extension of the time to respond to the EJR request nor filed objections to the Board's July 13, 2022 Scheduling Order granting that extension. As a result, it is clear that, through its filing of the federal litigation, King & Spalding has abandoned the Board's jurisdictional review process and appears to be challenging the Secretary's implementation at 42 C.F.R. §§ 405.1842(a)(4)(ii) and 405.1842(b)(2) of the 30-day period prescribed in § 1395oo(f)(1) as well as the Board's notice to the parties of its reliance on those regulations.

Moreover, the record is clear that King & Spalding filed a lawsuit in federal district court on August 1, 2022, *without notifying the Board or the opposing party*, of its intent to file the Complaint or the initiation of federal litigation. The Board finds that King & Spalding's decision to delay notice to the Board and the opposing parties of its filing of the litigation is tantamount to bad faith and actively created the confusion surrounding the status of these cases at the Board because it ignored the Board's July 13, 2022 Notice to the parties that, pursuant to 42 C.F.R. § 405.1842 and 42 U.S.C. § 1395oo(f)(1), the 30-day period for the Board to review an EJR request had not yet begun. Indeed, King & Spalding's action, taken without notice to the Board or the opposing parties, demonstrates that it had no intention of exhausting its administrative remedies before the Board. Pursuant to Board Rule 1.3 (Nov. 1, 2022),²³ King & Spalding had a duty to communicate early, and in good faith, with the Board and the opposing parties (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

1.3 Good Faith Expectations

In accordance with the regulations, the Board expects the parties to an appeal to communicate early, act in good faith, and attempt to negotiate a resolution to areas of misunderstanding and differences. The duty to communicate early and act in good faith applies to dealings with the opposing party, the Board, and/or any relevant nonparty.

Similarly, pursuant to Board Rule 5.2 (Nov. 1, 2021), King & Spalding, as the Providers' designated representative, is responsible for being familiar with, and following, Board rules and

²³ The recent changes to the Rules (effective Nov. 1, 2021) were first published in June 16, 2021 and, in advance of their effective date, invited comments from all interested individuals, providers, government contractors and other organization to be submitted by July 30, 2021. Subsequently on September 30, 2021, based on its review of that feedback, the Board then published further revisions to the Rules (effective Nov. 1, 2021). *See* Board Order No. 1 (available at: <https://www.cms.gov/files/document/revised-prrb-rules-v-30-cover-order-1-superseded-v-31.pdf>); Board Alerts 21 and 22 (available at <https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts>); Board Order No. 2 (<https://www.cms.gov/files/document/current-prrb-rules-v-31-cover-order-2-november-1-2021.pdf>).

procedures and governing regulations (including 42 C.F.R. § 405.1842(b)(2)), and timely responding to correspondence or requests from the Board or the opposing party:

5.2 Responsibilities

The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:

- The Board's governing statute at 42 U.S.C. § 1395oo;
- *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and*
- *These Rules*, which include any relevant Orders posted at <https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions> (see Rule 1.1).

Further, *the case representative is responsible for:*

- Ensuring his or her contact information is current with the Board, including a current email address and phone number;
- Meeting the Board's deadlines; and
- *Responding timely to correspondence or requests from the Board or the opposing party.*

Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.²⁴

These circumstances make clear that King & Spalding had a duty, pursuant to Board Rule 1.3, “to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty.” King & Spalding’s failure to comply with Board Rule 1.3, through prompt notification of the lawsuit on, or about, August 1, 2022 prejudiced the Board, FSS and the Medicare Contractors. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay or cease work on these group cases and the underlying participants in favor of other time-sensitive work. Finally, the Board’s September 2, 2022 Scheduling Order requiring additional briefing from the parties in the two cases was

²⁴ (Italics emphasis added.) See also *Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) (Circuit Court affirming the District Court’s grant of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating: “The court therefore granted summary judgment to the Board. Because the Board's procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm.”).

clearly warranted under 42 C.F.R. § 405.1842(e)(3) given the fact that the FY 2023 IPPS Final Rule appears to grant most, if not all, of the relief the Providers are seeking.

The Board admonishes King & Spalding for blatantly ignoring Board Rule 1.3 through its failure to communicate with the Board and the opposing party about the litigation it filed and its intention to abandon the Board's ongoing proceedings, which included:

1. The Board's ongoing jurisdiction and substantive claim review processes.
2. The development of the record in the two cases following the publication of the August 10, 2022 Final Rule, which modified the regulation at issue and will apply retroactively.

The regulation at 42 C.F.R. § 405.1842(h)(3)(iii) bars the Board from conducting any further proceedings. The Providers are pursuing the merits of their appealed issue(s) in the District Court for the District of Columbia, and there are no remaining issues beyond the EJR request.²⁵ Accordingly, consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and FRCP 62.1²⁶ the Board takes the following actions:

1. Closes these 2 group cases and removes them from the Board's docket;
2. Suspends completion of its jurisdictional and substantive claim review processes; and
3. Defers consideration of any potential remedial action based on King & Spalding's violations of the Board Rules and its governing regulations until there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and FRCP 62.1.

Accordingly, the Board hereby closes these cases and removes them from the Board's docket. The Board will conduct no further proceedings in these appeals absent a remand from the Administrator, pursuant to 42 C.F.R. 405.1877(g)(2).

Board Members Participating:

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

For the Board:

11/22/2022

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Jacqueline Vaughn, OAA

²⁵ The Board notes that, *in order for the Board to have jurisdiction over a group*, the group may only contain one legal issue per 42 C.F.R. § 405.1837(a) and, as such, there should be no other issues outside of the EJR request.

²⁶ See *supra* note 3.



DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: *Closure of Cases & Suspension of Jurisdictional & Substantive Claim Processes*

22-0224G King & Spalding CY 2018 DGME Fellow Penalty Present Year Group

22-0225G King & Spalding CY 2018 DGME Fellow Penalty Prior and Penultimate Years Group

Dear Messrs. Hettich and Leong:

As the parties are aware, King & Spalding, LLP (“King & Spalding”), the Providers’ designated representative, filed a consolidated request for expedited judicial review (“EJR”) on July 1, 2022 for the above-referenced optional group cases on the following issue:

[W]hether the formula for calculating the number of full-time equivalent (“FTE”) residents a hospital may count in a year for the purposes of direct graduate medical education [(“DGME”)] reimbursement, as contained in 42 C.F.R. [§] 413.79(c)(2)(iii), is unlawful because it penalizes hospitals that train “fellows” (*i.e.*, residents who are not in their initial residency period) while operating in excess of their FTE caps.¹

It has come to the Board’s attention that the Providers have filed a complaint in federal district court² to pursue the merits of their EJR request, notwithstanding the fact that the Board has not yet completed its jurisdictional review and not yet issued a determination on the EJR request. As set forth in more detail below, the Provider Reimbursement Review Board (“Board”) hereby takes the following actions consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure (“FRCP”) 62.1³:

1. Closes these 2 group cases; and
2. Suspends completion of its jurisdictional and substantive claim review processes.

¹ EJR Request at 1 (July 1, 2022). In addition, for two Provider that admittedly did not self-disallow this issue, those Providers seek to have the self-disallowance regulation at 42 C.F.R. § 413.24(j) declared unlawful. *Id.* at 2.

² *The Univ. of Vermont Med. Ctr. Inc., et al. v. Becerra*, 1:22-cv-2252 (D.D.C. Aug. 1, 2022).

³ FRCP 62.1 is entitled “Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal.” While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looks to it for guidance.

Procedural Background:

On July 1, 2022, King & Spalding initially filed an EJR request for Case Nos. 22-0224G and 22-0225G. Also on July 1, 2022, the Providers' Group Representative filed a consolidated Request to Change Lead Medicare Administrative Contractor ("MAC") in these two cases.⁴

The Board granted the request to change the MAC from Novitas Solutions, Inc. to WPS Government Health Administrators on July 8, 2022. However, *the Board found that the simultaneous filings of the EJR request and the change of MAC were prejudicial* to both the new lead Medicare Contractor and the Board in that the jurisdictional review and a finding of jurisdiction is a pre-requisite to review of an EJR request. Therefore, by letter dated July 25, 2022, consistent with the Board's authority,⁵ the Board granted an extension of time and issued a Scheduling Order that required the newly identified Medicare Contractor and/or Federal Specialized Services ("FSS") to respond to the EJR request on or before August 23, 2022, and the Providers to file their response to that filing on or before September 7, 2022. The Board also provided Notice of when the 30-day period for responding to the EJR request commenced, explaining that it would not commence until the Board completed its pre-requisite jurisdictional review of these optional groups, and that the Scheduling Order necessarily affected the 30-day period for the Board's determination of authority required to decide the EJR request.⁶ The Board clarified that it would continue its review of the jurisdiction in these optional group cases, as well as review the Providers' request for EJR, upon receipt of the requested information, or the September 7, 2022, filing deadline, whichever occurred first.

On August 10, 2022, the Secretary published the Final Rule on Hospital Inpatient Prospective Payment Systems ("IPPS") for Fiscal Year 2023 in the Federal Register.⁷ The IPPS Final Rule included a new payment formula for DGME costs that will be applied *retroactively*.⁸ Moreover, the Secretary modified the regulation at 42 C.F.R. § 413.79(c)(2)(iii) to state that, effective for cost reporting periods beginning on or after October 1, 2001, if the hospital's unweighted number of FTE residents exceeds the limit described in the final rule, and the number of weighted FTE residents in accordance with § 413.79(b) also exceeds that limit, the respective primary care and obstetrics and gynecology weighted FTE counts and other weighted FTE counts are adjusted to make the total weighted FTE count equal the limit. If the number of FTE residents weighted in accordance with § 413.79(b) does not exceed that limit, then the allowable weighted FTE count is the actual weighted FTE count. Further, the Secretary made a conforming change to the regulations text at 42 C.F.R. § 413.79(d)(3) regarding application of the 3-year rolling average to state that for cost reporting periods beginning on or after October 1, 2001, the hospital's weighted

⁴ The EJR request would have been served on the MAC at the time of the filing of the EJR, which is the original MAC of record, not the MAC to which the Providers were requesting that the Board change the MAC to.

⁵ 42 U.S.C. § 1395oo(e). See also 42 C.F.R. § 405.1868(a).

⁶ The Board's July 25, 2022 Notice provided a detailed discussion of the basis for this finding based on the application of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 (with particular emphasis on § 405.1842(b)(2) which address "Initiating EJR").

⁷ 87 Fed. Reg. 48,780 (Aug. 10, 2022).

⁸ *Id.* at 49,065-72.

FTE counts for the preceding two cost reporting periods are calculated in accordance with the payment formula at § 413.79(c)(2)(iii).

Through one letter for each case, each dated August 16, 2022, the Medicare Contractor indicated that it had no objections to the Providers' EJR request.

On September 2, 2022, the Board issued a Scheduling Order requiring additional briefing from the parties in the two cases. Specifically, the Board required the parties to supplement their filings related to the EJR request following the publication of the FY 2023 IPPS Final Rule. As a result of this subsequent legal development, the Board exercised its authority under 42 C.F.R. § 405.1842(e)(3) to require that the Group Representative provide a case-status update and confirm whether the EJR request has been rendered moot by the FY 2023 IPPS Final Rule or whether the participants in these groups remained committed to pursuing the EJR requests. If the participants remained committed to pursuing the EJR request, then they were to update the EJR request to: (i) discuss the impact of the Final Rule on the EJR requests challenging the Secretary's policy and regulation establishing the payment methodology for determining payments to hospitals for the direct costs of approved DGME programs, specifically the method of calculating DGME payments to teaching hospitals when those hospitals' weighted FTE counts exceed their FTE cap; and (ii) modify the EJR request, as relevant, based on this impact.

The Board's Scheduling Order also referenced its July 25, 2022 Notice of when the 30-day period to review an EJR request commences, and reaffirmed that this Notice remained in effect as the Board had not yet (and still has not) completed its jurisdictional review.

On September 23, 2022, King & Spalding responded and asserted that:

1. Their EJR request was not moot at that time because the Final Rule takes effect on October 1, 2022 and, as such, the Board continues to lack the authority to grant the relief requested for either of the two issues for which EJR was requested; and
2. Even after the 2023 Final Rule takes effect, the Board will continue to lack the authority to put aside CMS' self-disallowance regulation.

Further, King & Spalding informed the Board that, previously on August 1, 2022, the Providers had filed a complaint in the U.S. District Court for the District of Columbia seeking judicial review of their appeals pursuant to 42 U.S.C. § 1395oo(f)(1), in order to preserve their right to interest under 42 U.S.C. § 1395oo(f)(2). King & Spalding gave the following explanation of why it filed the Complaint in the federal district court:

As noted above, in order to preserve their right to interest, the Providers filed a complaint on August 1, 2022, which was 31 days after they had filed their EJR request, with all required materials, with the Board. *See* 42 U.S.C. § 1395oo(f)(1) (allowing a provider to file a complaint if it has not received the Board's EJR decision "within thirty days after the Board receives" the "documents and

materials as the Board shall require for purposes of rendering such determination”). **The Providers are aware that the Board is bound by CMS’s regulation which interprets 42 U.S.C. § 1395oo(f)(1) to mean that the thirty-day clock does not begin to run until after the Board has determined that it has jurisdiction over the appeal and that there is no time limit for the Board to determine jurisdiction.** *See* 42 C.F.R. § 405.1842(b)(2). We respectfully disagree with that interpretation of the statute for multiple reasons and have noted our disagreement in our complaint before the court. (Notably, while some other courts have upheld the agency’s regulation in this regard, it has not been addressed by the D.C. Circuit.)

King & Spalding asserts that further proceedings in these cases should be stayed pending the resolution of that Complaint, citing 42 C.F.R. § 405.1842(h)(3)(iii) and 73 Fed. Reg. 30189, 30214-15 (May 23, 2008).

On October 6, 2022, the Medicare Contractor filed a Motion to dismiss these cases pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), which bars the Board from conducting any further proceedings once the provider commences action in Federal Court. The Providers had 30 days to respond to the Motion per Board Rule 44.3. However, more than 30 days has passed, and the Providers have failed to respond.

King and Spalding ***filed a Complaint in the U.S. District Court for the District of Columbia regarding the merits of their EJR request as filed in these appeals***, on August 1, 2022.⁹ This is a significant action by the Providers that impacts the Board proceedings because 42 C.F.R. § 405.1842(h)(3) directs the Board to conduct no further proceedings under such circumstances:

(h) Effect of final EJR decisions and lawsuits on further Board proceedings –

(3) Provider lawsuits. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.

⁹ *See supra* note 2 (A copy of the Complaint is attached to the Providers’ Response to Scheduling Order filed on Sept. 23, 2022).

(iii) If the lawsuit is filed before a final EJR decision is issued on the legal question, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved.¹⁰

Accordingly, the filing of this Complaint in Federal District Court made clear that the Providers had abandoned the Board's jurisdictional and substantive claim review processes. In the Complaint, the Group Representative alleges that the Board did not rule on the Providers' requests for EJR within the 30-day timeframe, as required by 42 U.S.C. § 1395oo(f)(1). Based on this allegation, the Plaintiffs in these groups claimed that they had 60 days, after the expiration of the alleged 30-day EJR review timeframe, in which to file a civil action challenging the Board's lack of decision.¹¹

Board Findings and Ruling:

The Board must decide what effect the Providers' filing of a lawsuit has on the proceedings before the Board in connection with the above-referenced group cases.

A. The 30-day Period for Responding to the EJR Requests Has Not Yet Begun and Bypassing the Completion of that Process Automatically Raises Potential Fraud, Waste and Abuse Concerns.

As discussed in more detail above, the Board's correspondence in these cases notified the parties on multiple occasions, in detail, that the 30-day period for EJR review does not begin until the Board completes its jurisdictional review and finds jurisdiction. Set forth below is a summary of that explanation.

Parties to a Board appeal may request EJR pursuant to the provisions of 42 U.S.C. § 1395oo(f)(1) which states, in relevant part:

Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider ***may file*** a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such

¹⁰ (Emphasis added.)

¹¹ Complaint, ¶ 47.

determination). *The Board shall render such determination in writing within thirty days **after the Board receives the request and such accompanying documents and materials**, and the determination shall be considered a final decision and not subject to review by the Secretary.*¹²

To implement this statutory provision, the Secretary promulgated the regulation at 42 C.F.R. § 405.1842, setting forth the process for obtaining EJR, and the Board's obligations under the statute. As demonstrated by the following excerpts, 42 C.F.R. § 405.1842 makes clear that the 30-day clock for processing an EJR request does not begin until *after* the Board rules on jurisdiction:

(a) *Basis and scope.* (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter** (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).

(2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).

(4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act *only if*—

(i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue** and a determination by the Board that it has no authority to decide the relevant legal question; or

(ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days after finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete.**

¹² (Emphasis added).

(b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question.**

(2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . Under paragraphs (d) and (e) of this section, a **provider may request** a determination of the Board's authority to decide a legal question, but **the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act [i.e., 42 U.S.C. § 1395oo(f)(1)] does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete.**¹³

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period “does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider’s request is complete.”¹⁴ Moreover, the Board is bound by this regulation because, as stated in 42 C.F.R. § 405.1867, “[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act ***and regulations issued thereunder*** . . .” Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.¹⁵

¹³ (Emphasis added).

¹⁴ 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: “In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(1), ***we would emphasize that a Board finding that it has jurisdiction over the specific matter at issue is a prerequisite for its determination of its authority to decide the legal question,*** and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR “[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].” In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision, that the 30-day time limit specified in section 1878(f)(1) of the Act for the Board to act on a provider's complete request does not begin to run until the Board has found jurisdiction*** on the specific matter at issue.” (emphasis added)).

¹⁵ (Emphasis added.)

Thus, it is clear that the 30-day clock does not start until *after* the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request.¹⁶

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR “*if [it] may obtain a hearing under subsection (a). . .*”¹⁷ Thus, as the Court in *Alexandria Hospital v. Bowen* (“*Alexandria*”)¹⁸ noted, “the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals.”¹⁹ The Court in *Alexandria* continued:

Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal.* The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction.* EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .

The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is without merit.*²⁰

¹⁶ Note that the Board's use of the term “stay” (as used in this and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

¹⁷ 42 U.S.C. § 1395oo(f)(1) (emphasis added).

¹⁸ *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986) (hereinafter “*Alexandria*”).

¹⁹ *Alexandria* at 1244. See H.R. Rep. No. 96-1167, reprinted in 1980 U.S. Code Cong. & Ad. News at 5757. See also *San Francisco Gen. Hosp. v. Shalala*, No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan*, 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen*, Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).

²⁰ *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, would still be able to prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.²¹ Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

The above discussion makes it clear that, per the regulations at 42 C.F.R. §§ 405.1842(a)(4)(i) and 405.1842(b)(2), the 30-day EJR review period, specified at 42 U.S.C. § 1395oo(f)(1), does not begin until the Board completes its jurisdictional review process and finds jurisdiction.

B. Status of the Cases and the Board's Jurisdictional Review

King and Spalding filed its lawsuit in federal district court on August 1, 2022 – before the Board had completed its jurisdictional review to confirm whether it had jurisdiction to hear all of the disputes raised in the providers' EJR request *and* whether the record was sufficiently developed following the August 10, 2022 Final Rule. Having sufficient time to complete the jurisdictional and substantive claim review²² process is important to ensure that the groups, and all the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules. Without a proper jurisdictional review, fraud, waste and abuse concerns could arise. Specifically, absent a proper jurisdictional review, there is a risk of prohibited participation of CIRP providers in optional groups.

As stated above, 42 C.F.R. § 405.1842(h)(3)(iii) specifies that, “[i]f the lawsuit is filed before a final EJR decision is issued on the legal question, *the Board may not conduct any further proceedings* on the legal question or the matter at issue until the lawsuit is resolved.”²³

King & Spalding has made clear in its filings before the Board and in Court that it disagrees with the Board's interpretation of the mandatory jurisdictional requirements in EJR proceedings and the need to resolve any jurisdictional and substantive challenges before ruling on an EJR request. For the cases in which the Board has not yet issued an EJR determination, its lawsuit is based on a contention that the Board failed to process its EJR request within the 30-day period prescribed in 42 U.S.C. § 1395oo(f)(1).

²¹ It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules.

²² As stated in Board Rule 44.5, “[t]he Board adoption 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.”

²³ (Emphasis added.)

Significantly, the Board consistently notified the parties that the 30-day period had not begun because the Board had not completed its jurisdictional and substantive claim review. *However, at no point in the proceedings before the Board has King & Spalding referenced or challenged the Board's stated reliance on 42 C.F.R. § 405.1842(b)(2) in issuing that notification or otherwise challenged the validity of that regulation until after it filed its Complaint in federal district court.* In this regard, the Board notes that King & Spalding did not file objections to the Board's July 25, 2022 Scheduling Order granting an extension. As a result, it is clear that, through its filing of the federal litigation, King & Spalding has abandoned the Board's jurisdictional review process and appears to be challenging the Secretary's implementation at 42 C.F.R. §§ 405.1842(a)(4)(ii) and 405.1842(b)(2) of the 30-day period prescribed in § 1395oo(f)(1) as well as the Board's notice to the parties of its reliance on those regulations.

Moreover, the record is clear that King & Spalding filed a lawsuit in federal district court on August 1, 2022, *without notifying the Board or the opposing party*, of its intent to file the Complaint or the initiation of federal litigation. The Board finds that King & Spalding's decision to delay notice to the Board and the opposing parties of its filing of the litigation is tantamount to bad faith and actively created the confusion surrounding the status of these cases at the Board because it ignored the Board's July 25, 2022 Notice to the parties that, pursuant to 42 C.F.R. § 405.1842 and 42 U.S.C. § 1395oo(f)(1), the 30-day period for the Board to review an EJR request had not yet begun. Indeed, King & Spalding's action, taken without notice to the Board or the opposing parties, demonstrates that it had no intention of exhausting its administrative remedies before the Board. Pursuant to Board Rule 1.3 (Nov. 1, 2022),²⁴ King & Spalding had a duty to communicate early, and in good faith, with the Board and the opposing parties (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

1.3 Good Faith Expectations

In accordance with the regulations, the Board expects the parties to an appeal to communicate early, act in good faith, and attempt to negotiate a resolution to areas of misunderstanding and differences. The duty to communicate early and act in good faith applies to dealings with the opposing party, the Board, and/or any relevant nonparty.

Similarly, pursuant to Board Rule 5.2 (Nov. 1, 2021), King & Spalding, as the Providers' designated representative, is responsible for being familiar with, and following, Board rules and procedures and governing regulations (including 42 C.F.R. § 405.1842(b)(2)), and timely responding to correspondence or requests from the Board or the opposing party:

²⁴ The recent changes to the Rules (effective Nov. 1, 2021) were first published in June 16, 2021 and, in advance of their effective date, invited comments from all interested individuals, providers, government contractors and other organization to be submitted by July 30, 2021. Subsequently on September 30, 2021, based on its review of that feedback, the Board then published further revisions to the Rules (effective Nov. 1, 2021). *See* Board Order No. 1 (available at: <https://www.cms.gov/files/document/revised-prrb-rules-v-30-cover-order-1-superseded-v-31.pdf>); Board Alerts 21 and 22 (available at <https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts>); Board Order No. 2 (<https://www.cms.gov/files/document/current-prrb-rules-v-31-cover-order-2-november-1-2021.pdf>).

5.2 Responsibilities

The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:

- The Board’s governing statute at 42 U.S.C. § 1395oo;
- *The Board’s governing regulations at 42 C.F.R. Part 405, Subpart R*; and
- *These Rules*, which include any relevant Orders posted at <https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions> (see Rule 1.1).

Further, *the case representative is responsible for:*

- Ensuring his or her contact information is current with the Board, including a current email address and phone number;
- Meeting the Board’s deadlines; and
- *Responding timely to correspondence or requests from the Board or the opposing party.*

Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.²⁵

These circumstances make clear that King & Spalding had a duty, pursuant to Board Rule 1.3, “to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty.” King & Spalding’s failure to comply with Board Rule 1.3, through prompt notification of the lawsuit on, or about, August 1, 2022 prejudiced the Board, FSS and the Medicare Contractors. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay or cease work on these group cases and the underlying participants in favor of other time-sensitive work. Finally, the Board’s September 2, 2022 Scheduling Order requiring additional briefing from the parties in the two cases was clearly warranted under 42 C.F.R. § 405.1842(e)(3) given the fact that the FY 2023 IPPS Final Rule appears to grant most, if not all, of the relief the Providers are seeking.

²⁵ (Italics emphasis added.) See also *Baptist Mem’l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) (Circuit Court affirming the District Court’s grant of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating: “The court therefore granted summary judgment to the Board. Because the Board’s procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm.”).

The Board admonishes King & Spalding for blatantly ignoring Board Rule 1.3 through its failure to communicate with the Board and the opposing party about the litigation it filed and its intention to abandon the Board's ongoing proceedings, which included:

1. The Board's ongoing jurisdiction and substantive claim review processes.
2. The development of the record in the two cases following the publication of the August 10, 2022 Final Rule, which modified the regulation at issue and will apply retroactively.

The regulation at 42 C.F.R. § 405.1842(h)(3)(iii) bars the Board from conducting any further proceedings. The Providers are pursuing the merits of their appealed issue(s) in the District Court for the District of Columbia, and there are no remaining issues beyond the EJR request.²⁶ Accordingly, consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1²⁷ the Board takes the following actions:

1. Closes these 2 group cases and removes them from the Board's docket;
2. Suspends completion of its jurisdictional and substantive claim review processes; and
3. Defers consideration of any potential remedial action based on King & Spalding's violations of the Board Rules and its governing regulations until there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and FRCP 62.1.

Accordingly, the Board hereby closes these cases and removes them from the Board's docket. The Board will conduct no further proceedings in these appeals absent a remand from the Administrator, pursuant to 42 C.F.R. § 405.1877(g)(2).

Board Members Participating:

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

For the Board:

11/22/2022

 Clayton J. Nix

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

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Jacqueline Vaughn, OAA

²⁶ The Board notes that, *in order for the Board to have jurisdiction over a group*, the group may only contain one legal issue per 42 C.F.R. § 405.1837(a) and, as such, there should be no other issues outside of the EJR request.

²⁷ See *supra* note 3.



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Board Decision***
The Stamford Hospital (Provider Number 07-0006)
FYE: 09/30/2013
Case Number: 16-1223

Dear Mr. Ravindran,

The Provider Reimbursement Review Board (“Board”) has reviewed the documents in the above referenced appeal and dismisses the Disproportionate Share Hospital (“DSH”) Payment / Supplemental Security Income (“SSI”) Percentage - Provider Specific issue for the reasons set forth below.

Pertinent Facts

On September 14, 2015, the Provider was issued a final Notice of Program Reimbursement (“NPR”) for fiscal year end September 30, 2013.

On March 14, 2016, the Board received the Provider’s individual appeal request. The initial Individual Appeal Request contained eleven (11) issues:

1. DSH Payment/SSI Percentage – Provider Specific
2. DSH/SSI Percentage – Systemic Errors¹
3. DSH Payment - SSI Fraction/Medicare Managed Care Part C Days²
4. DSH Payment - SSI Fraction/Dual Eligible Days³
5. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days⁴
6. DSH Payment – Medicaid Fraction/Dual Eligible Days⁵
7. DSH Payment – Medicaid Eligible Days

¹ On November 29, 2016, this issue was transferred to PRRB Case No. 16-1141G.

² On November 29, 2016, this issue was transferred to PRRB Case No. 16-1143G.

³ On November 29, 2016, this issue was transferred to PRRB Case No. 16-1142G.

⁴ On November 29, 2016, this issue was transferred to PRRB Case No. 16-1144G.

⁵ On November 29, 2016, this issue was transferred to PRRB Case No. 16-1145G.

8. DSH Payment – Medicare Managed Care Part C Days⁶
9. DSH Payment – Dual Eligible Days⁷
10. DSH – Medicaid Eligible Patient Days – Connecticut State Administered General Assistance: DSH Payment Adjustment⁸
11. Intern & Resident FTE CAP (Provider Specific)

The remaining issues on appeal are the DSH Payment/SSI Percentage – Provider Specific issue, the DSH Payment - Medicaid Eligible Days issue, and the Intern & Resident FTE Cap (Provider Specific) issue.

In their Individual Appeal Request, the Provider summarizes its DSH/SSI Percentage – Provider Specific issue as follows:

The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

...

The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.⁹

The Provider described its DSH/SSI Percentage – Systemic Errors issue, which has been transferred to a group appeal, as whether the Medicare/SSI Fraction used to calculate their DSH payment accurately and correctly counted the number of patient days to be included therein. More specifically, Provider lists the following reasons for challenging its SSI percentage:

1. Availability of MEDPAR and SSA records,
2. Paid days vs Eligible days,
3. Not in agreement with provider's records,
4. Fundamentals problems in the SSI percentage calculation,
5. Covered days vs Total days, and
6. Failure to adhere to required notice and comment rulemaking procedures.¹⁰

⁶ On November 29, 2016, this issue was transferred to PRRB Case No. 16-1144G.

⁷ On November 29, 2016, this issue was transferred to PRRB Case No. 16-1145G.

⁸ On November 28, 2016, this issue was transferred to PRRB Case No. 17-0566G.

⁹ Issue Statement at 1. (Mar. 14, 2016).

¹⁰ *Id.* at 2.

MAC's Jurisdictional Challenge

On May 16, 2018, the Medicare Administrative Contractor (“MAC”) filed a Jurisdictional Challenge. The MAC argues that the DSH SSI Percentage - Provider Specific issue and the DSH SSI Percentage - Systemic issue are considered the same issue by the Board, and cites several past Board decisions to that end.¹¹ The MAC also cites Board Rule 4.5.¹²

A provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group).¹³

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.¹⁴ The Provider has not filed a response in this case and the time for doing so has elapsed.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), 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 (or \$50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage - Systemic Error issue that is being appealed in Case No. 16-1141G.

The DSH/SSI Percentage - Provider Specific issue in the present appeal concerns “whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation.”¹⁵ The Provider's legal basis for its DSH/SSI Percentage - Provider Specific issue asserts that the Medicare Contractor “did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i).”¹⁶ The Provider argues that “its SSI percentage published by the Centers

¹¹ Medicare Contractor's Jurisdictional Challenge at 2 (May 16, 2018).

¹² PRRB Board Rules v. 1.3 (July 1, 2015).

¹³ PRRB Board Rules v. 3.1 (Nov. 1, 2021).

¹⁴ PRRB Board Rule 44.3, v. 3.1 (Nov. 1, 2021).

¹⁵ Issue Statement at 1.

¹⁶ *Id.*

for Medicare and Medicaid Services was incorrectly computed . . .” and it “. . . specifically disagrees with the [Medicare Contractor]’s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary’s Regulations.”¹⁷

The Provider’s DSH SSI Percentage - Systemic Errors issue in group Case No. 16-1141G also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106. Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage - Systemic Errors issue in Case No. 16-1141G. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6.1,¹⁸ the Board dismisses this aspect of the DSH/SSI Percentage - Provider Specific issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not “specific” to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group in Case No. 16-1141G. Further, any alleged “systemic” issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.¹⁹ Provider’s reliance upon referring to Issue 1 as “Provider Specific” and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged “provider specific” errors can be distinguished from the alleged “systemic” issue rather than being subsumed into the “systemic” issue appealed in Case No. 16-1141G.

The second aspect of the DSH SSI Percentage - Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider’s DSH percentage, “[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . .” Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Further, the Provider’s cost reporting period ends on 9/30, which is the same as the federal fiscal year end. Thus, any realignment would have no effect. Therefore, the Board dismisses this portion of the issue.

¹⁷ *Id.*

¹⁸ *Supra* n.5.

¹⁹ The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. See *Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

Conclusion

The Board has dismissed the DSH/SSI Percentage - Provider Specific issue from Case No. 16-1233. The appeal remains open, as other issues are pending.

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

Board Members Participating:

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

For the Board:

11/28/2022

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Member

Signed by: Kevin D. Smith -A

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Bryan Nowicki
Reinhart Boerner Van Deuren, S.C.
22 East Mifflin Street, Suite 700
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RE: Notice of Dismissal

Seasons Hospice & Palliative Care of Southern Florida (Prov. No. 10-1543)
Case Number: 19-0594; FYE 09/30/2017
Case Number: 20-0570; FYE 09/30/2018
Case Number: 20-0571; FYE 10/31/2016

Dear Mr. Nowicki:

You are the representative in the above-referenced cases relating to the Validity of Hospice Cap Repayment Demands/Regulation/Sequestration issue pending on the Provider Reimbursement Review Board's ("PRRB or Board") docket.

On October 31, 2022, the Board requested a status update to confirm whether, in light of recent U.S. Court of Appeals decisions,¹ the Provider remained committed to pursuing the merits of the substantive issue within fifteen days of the letter's signature date. At the time, you were informed that failing to timely respond to the request may result in dismissal pursuant to the Board's authority under 42 C.F.R. § 405.1868.

To date, there has been no action or communication since the Board's letter. In accordance with Board Rule 41.2, the Board may dismiss a case if it has a reasonable basis to believe that the issues have been fully settled or abandoned, or upon failure of the provider or group to comply with Board procedures or filing deadlines. The Board finds the Provider failed to comply with the Request for Status within the Board's deadline and has effectively abandoned the appeal. The cases are hereby closed.

¹ *Gentiva Health Servs., Inc. v. Becerra*, 31 F.4th (D.C. Cir. 2022) and *Silverado Hospice, Inc. v. Becerra*, 42 F.4th 1112 (9th Cir. 2022).

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Ratina Kelly, CPA

FOR THE BOARD:

11/28/2022

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Member

Signed by: Kevin D. Smith -A

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Wilson Leong, Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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140 N. Union Ave, Suite F350
Farmington, UT 84025

RE: Notice of Dismissal

Heritage Health Services (Provider Number 13-1568)
Case No. 19-0677; FYE 10/31/2015
Independence Home Care (Provider Number 46-1585)
Case No. 19-1431; FYE 09/30/2017

Dear Mr. Frasure:

You are the representative in the above-referenced cases relating to the Validity of Hospice Cap Repayment Demands/Regulation/Sequestration issue pending on the Provider Reimbursement Review Board's ("PRRB or Board") docket.

On October 31, 2022, the Board requested a status update to confirm whether, in light of recent U.S. Court of Appeals decisions,¹ the Provider remained committed to pursuing the merits of the substantive issue within fifteen days of the letter's signature date. At the time, you were informed that failing to timely respond to the request may result in dismissal pursuant to the Board's authority under 42 C.F.R. § 405.1868.

To date, there has been no action or communication since the Board's letter. In accordance with Board Rule 41.2, the Board may dismiss a case if it has a reasonable basis to believe that the issues have been fully settled or abandoned, or upon failure of the provider or group to comply with Board procedures or filing deadlines. The Board finds the Provider failed to comply with the Request for Status within the Board's deadline and has effectively abandoned the appeal. The cases are hereby closed.

Board Members Participating:

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

¹ *Gentiva Health Servs., Inc. v. Becerra*, 31 F.4th (D.C. Cir. 2022) and *Silverado Hospice, Inc. v. Becerra*, 42 F.4th 1112 (9th Cir. 2022).

FOR THE BOARD:

11/28/2022

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Member

Signed by: Kevin D. Smith -A

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Judith Cummings, CGS Administrators (J-15)
Wilson Leong, Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Board Decision – SSI Percentage (Provider Specific) and Medicaid Eligible Days***
Longview Regional Medical Center (Prov. No. 45-0702)
FYE 12/31/2013
Case No. 16-1016

Dear Mr. Ravindran,

The Provider Reimbursement Review Board (“Board”) has reviewed the documentation in the above referenced appeal in response to the Jurisdictional Challenge and Motion to Dismiss filed by the Medicare Contractor (“MAC”). The decision of the Board is set forth below.

Background:

A. Procedural History for Case No. 16-1016

On February 19, 2016, the Board received Provider’s Individual Appeal Request appealing their August 19, 2015 Notice of Program Reimbursement (“NPR”) for fiscal year ending December 31, 2013. The initial appeal contained the two (2) following issues:

- **Issue 1:** DSH: SSI percentage (Provider Specific)
- **Issue 2:** DSH – Medicaid Eligible Days

On May 17, 2018,¹ the Medicare Contractor filed a jurisdictional challenge arguing that the Board lacks jurisdiction over the DSH/SSI – Provider Specific issue. Significantly, the Provider did not file a response to the Jurisdictional Challenge within the 30 days allotted under Board Rule 44.4.3 which specifies: “Providers must file a response within thirty (30) days of the Medicare contractor’s jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.”

Additionally, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue on March 2, 2022 arguing that the issue should be dismissed for failure to provide an

¹ The Medicare Contractor filed a renewed Jurisdictional Challenge on February 9, 2022.

eligibility listing of the additional days being claimed on appeal. As with the Jurisdictional Challenge, the Provider did not file a response to the Motion to Dismiss.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 15-2694GC

The Provider's appeal request described Issue 1: DSH/SSI – Provider Specific issue as follows:

The provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

...

The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.²

As the Provider is commonly owned by Community Health Systems, Inc. the Provider was also directly added to the common issue related party ("CIRP") group under Case No. 15-2694GC, *Community Health Systems 2013 Post 1498-R DSH SSI Data Match CIRP*, on September 11, 2015. The Group Issue Statement for that case is stated as follows:

... The Provider asserts that the Medicare Proxy is improperly understated due to a number of factors, including CMS's inaccurate and improper matching or use of data along with policy changes to determine both the number of Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A patient days in the denominator, as utilized in the calculation of the Medicare percentage of low income patients for DSH purposes

CMS's improper treatment and policy changes resulted in an underpayment to the Providers as DSH program eligible providers of services to indigent patients, and includes any other related adverse impact to DSH payments Also, this treatment is not consistent with Congressional intent to reimburse hospitals for treatment of indigent patients when determining DSH program eligibility and payment pursuant to 42 U.S.C. § 1395ww(d)(5)(F), 42 C.F.R. § 412.105, Medicare Intermediary Manual § 3610.15, or any other applicable statutes, regulations, program guidelines, or case law.

² Individual Appeal Request at Tab 3.

CMS issued Ruling 1498-R . . . [which] sets forth . . . a revised and corrected data match process CMS would use to determine Providers' appropriate Medicare proxies and overall DSH adjustments. Providers assert that errors and problems still exist in the data match process, as well as improper policy changes by CMS, which are resulting in understated DSH adjustments for Providers

The amount in controversy listed for the Provider over Issue 1 in its individual appeal request was \$89,876.

The Provider submitted its Final Position Paper on January 11, 2022. The following is the Provider's *complete* position on Issue 1 set forth therein:

Calculation of the SSI Percentage

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).

The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 2, which shows that the amount in controversy for the issue is \$89,876.

MAC’S Contentions:

Issue 1 – DSH SSI Percentage (Provider Specific)

On May 17, 2018,³ the Medicare Contractor filed a jurisdictional challenge arguing that the Board lacks jurisdiction over the DSH/SSI – Provider Specific issue. because the decision to realign a hospital’s SSI percentage with its fiscal year end is a hospital election, not an appealable Medicare Contractor determination, and since the Provider did not request an SSI realignment, appealing this issue is premature since there was no final determination. Additionally, it is noted in its Final Position Paper that the issue is duplicative of the SSI Data Match issue in group case 15-2694GC, to which Provider was directly added on September 11, 2015.

Issue 2 – DSH Medicaid Eligible Days

On March 2, 2022, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the issue should be dismissed for failure to provide an eligibility listing of the additional days being claimed on appeal. It outlines the Board’s Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 413.24(c), which places the burden production on the Provider with regard to furnishing this documentation. Finally, it notes that both the Provider’s Preliminary and Final Position Papers indicate that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 61 months since the instant appeal was filed, despite repeated requests for such a listing.

Provider’s Response:

The Provider did not file a response to the Jurisdictional Challenge or the Motion to Dismiss by the April 1, 2021 deadline but instead filed a request to postpone the hearing on April 1, 2021 which references the Motion to Dismiss. As previously noted, Board Rule 44.4.3 which specifies: “Providers must file a response within thirty (30) days of the Medicare contractor’s jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.”

On March 31, 2022, the Provider changed its representative to QRS. On April 1, 2022, ***just eleven (11) days prior to the hearing scheduled for April 12***, the Provider filed a Request for Postponement rather than directly responding to or refuting the Motion to Dismiss. The request for postponement claims that a reopening request was filed with the Medicare Contractor reopening department on May 24, 2021 but was denied:

³ The Medicare Contractor filed a renewed Jurisdictional Challenge on February 9, 2022.

The . . . case was pursued with an intent to be reopened in which listings were submitted to the [Medicare Contractor] *reopening department* on May 24, 2021 (Exhibit 1). Subsequently, the Provider received a reopening denial notification from the MACH in which the Provider now intends to pursue the Medicaid Eligible Day issue through the appeal process.

Significantly, the copy of the alleged reopening request included at Exhibit 1 neither cites Case No. 16-1016 nor indicates how many days remain in dispute, nor includes FSS as a carbon copy.

Notwithstanding the Medicare Contractor's denial of the reopening request and pending Motion to Dismiss, the Provider states:

The Provider has recently communicated with [the MAC's] reopening department to share the submission of *additional Medicaid days*⁴ with the appeals department. The next steps are to receive and provide support for the sample, finalize the audit/review adjustments, and draft an administrative resolution.

The request for postponement confirms that the Medicare Contractor opposes that postponement giving the Motion to Dismiss that it had previously filed but failed to explicitly refute or oppose the Motion to Dismiss:

The MAC does not agree with a postponement with their recent motion to dismiss filing (Exhibit 2) due to an additional Medicaid listing never being received. The Provider actively pursued the issue through the reopening process with the intention to withdraw the issue and close the case, but a denial of reopening was received. Since the Provider submitted the additional day's listing to the MAC on May 24, 2021, to WPS's reopening department which is now shared with the appeals department the MAC now has a listing to audit and ultimately resolve.

Board Analysis and Decision:

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

⁴ (Emphasis added.)

A. SSI Provider Specific

The analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI (Systemic Errors) issue that was appealed in Group Case No. 15-2694GC.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was appealed in Case No. 15-2694GC. The first aspect of Issue 1 in the present appeal concerns “whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation.”⁵ The Provider’s legal basis for this aspect of Issue 1 is simply that the Medicare Contractor “did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i).”⁶ Similarly, the Provider argues that “it[s] SSI percentage published by [CMS] was incorrectly computed . . .” and it “. . . [s]pecifically . . . disagrees with the MAC’s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary’s Regulations.”⁷ Issue 2, transferred to group Case No. 13-3694G, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the appealed issue in Case No. 15-2694GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue from the instant case.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not “specific” to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 15-2694GC. Further, any alleged “systemic” issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.⁸ Provider is misplaced in

⁵ Individual Appeal Request, Issue 1.

⁶ *Id.*

⁷ *Id.*

⁸ The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. See *Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

referring to Issue 1 as “Provider Specific” and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged “provider specific” errors can be distinguished from the alleged “systemic” issue rather than being subsumed into the “systemic” issue appealed in Case No. 15-2694GC.

Furthermore, the Board notes that Provider’s Final Position Paper did not provide any basis upon which to distinguish the two SSI issues. Accordingly, the Board finds that the DSH/SSI Provider Specific Issue failed to comply with Board Rule 25 governing the content of position papers, which requires position papers “to be *fully* developed and include *all available* documentation necessary to provide a *thorough understanding* of the parties’ positions.”⁹ Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged “errors” in its Final Position Paper and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPSS Final Rule, “[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital’s patients eligible for both SSI and Medicare at the hospital’s request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital’s fiscal year differs from the Federal fiscal year, for the **months included in the 2 Federal fiscal years that encompass the hospital’s cost reporting period.*** Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to*

⁹ (Emphasis added.)

decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year. The data set made available to hospitals will be the **same data set** CMS uses to calculate the Medicare fractions for the Federal fiscal year.” Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services (“CMS”) and in some cases on a self-service basis as explained on the following webpage:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.¹⁰ This CMS webpage describes access to DSH data *from 1998 to 2017* as follows: “DSH is now a self-service application. This **new self-service process** enables you to enter your data request(s) and retrieve your data files through the CMS Portal.”¹¹

Accordingly, the Board must find that Issues 1 and the group issue in Group Case 15-2694GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider’s DSH percentage, “[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request...” Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider’s DSH SSI Percentage realignment as such there is no “determination” to appeal and the appeal of this issue is otherwise premature.

B. DSH Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider states Issue 2 as:

Statement of the Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital (“DSH”) calculation.

¹⁰ (Last accessed Nov. 21, 2022.)

¹¹ (Emphasis added.)

Statement of the Legal Basis

The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.

The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.¹²

The amount in controversy calculation and protested item documentation for this issue suggests that there are 182 Medicaid eligible days at issue. However, the Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

On January 11, 2022, the Provider filed its Final Position Paper in which it indicated that it would be sending the eligibility listing under separate cover.¹³ Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case (*e.g.*, whether there remained 182 as suggested in the appeal request or more or less). Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

Calculation of Medicaid Eligible Days

Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations. The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir.

¹² *Id.*

¹³ Provider's Final Position Paper at 8 (Jan. 11, 2022).

1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).

The Centers for Medicare and Medicaid Services (“CMS”, formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

[T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Base on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its’ [*sic*] 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with its appeal notes a net impact of \$504,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider’s filing of the position paper and indeed the postponement request suggests that less than \$70,000 remains in dispute for this issue.¹⁴

Board Rule 7.3.1.2 (Nov. 2021) states:

No Access to Data

If the Provider elects not to claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

¹⁴ See *infra* note 23.

Notably, the Provider has not included a list of additional Medicaid eligible days with its Final Position Paper or submitted such a list under separate cover. The Medicare Contactor, thus, asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.¹⁵

42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

(2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper *must set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue.*

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions.*¹⁶

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (July 2015) states:

If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Similarly, with regard to position papers,¹⁷ Board Rule 25.2.1 requires that “the parties must exchange *all available* documentation as exhibits to fully support your position.”¹⁸ This requirement is consistent with 42 C.F.R. § 405.1853(b)(3) as well as the June 16, 2021 Notice of Hearing that set the deadline for the final position paper stating:

Provider’s Final Position Paper – For each remaining issue, the position paper must state the *material* facts that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), and provide arguments applying

¹⁵ See also Board’s jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency’s calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

¹⁶ (Emphasis added.)

¹⁷ The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. See Board Rule 27.2.

¹⁸ (Emphasis added.)

the material facts to the controlling authorities. This filing must also include *any* exhibits the Provider will use to support its position. See Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.¹⁹

Consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.²⁰

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

¹⁹ (Footnote omitted and emphasis added.) See *supra* note 17.

²⁰ (Emphasis added.)

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures,
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for *each* Medicaid patient day claimed"²¹ and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue *as required by the controlling regulations and Board Rules*. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. The fact that the Provider alleges in its April 1, 2022 postponement request that it submitted a listing to the Medicare Contractor *reopening department* on May 24, 2022 does not cure the above discussed deficiencies and, for purposes of Board proceedings, is *not* proper service to the opposing party under Board Rule 3.4 (indeed, it does not even reference Case No. 16-1016 and, as such, cannot be properly characterized as pursuing this case through reopening consistent with Board Rule 47.2.2).²² That listing was required to be part of the final position paper unless the conditions in Board Rules 25.2.2 governing unavailable and omitted documents were satisfied. Indeed, even at that late date, the Provider failed *to file* with the Board a copy of that listing (with appropriate redactions per Board Rule 1.4) much less confirm exactly how many days *remain* in dispute.²³

The Board finds that the number and identification of Medicaid eligible days at issue in this case are material facts and that the Provider has failed to comply with the Board's procedures with

²¹ (Emphasis added.)

²² FSS is the designated representative of the Medicare Contractor but FSS was not even included as a carbon copy on the request for reopening included at Exhibit 1 to coordinate a potential agreement under 47.2.2 for withdrawal of this issue from Case No. 16-1016 while reopening is pursued. Indeed, the alleged reopening request does not even reference the pending Board appeal under Case No. 16-1016 to allow the reopening department to understand that the Provider had a matter pending before the Board for FY 2013. Finally, Exhibit 1 does not include a copy of the days listing referenced in that document.

²³ See *supra* note 20. Indeed, the Board notes that the original amount in controversy in the appeal request for Issue 2 (Medicaid Eligible Days) was \$504,000. However, in the reopening request that is attached as Exhibit 1 to the April 1, 2021 postponement request, the Provider indicates that there is now less than \$70,000 in dispute for Issue 2. This suggests that since the appeal was filed, the number of days in dispute has become significantly less; however, again, there is no documentation in the record as to what those remaining disputed days are.

regard to filing its position papers and supporting documentation. In particular, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.²⁴ Accordingly, the Board dismisses the Medicaid Eligible Days issue pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b). The Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative and, notwithstanding, QRS failed to provide the Medicaid eligible days listing with its preliminary position paper.²⁵

C. Postponement Request

Finally, with regard to the Provider's postponement request submitted April 1, 2022, the Board denies the request. Board Rule 30.3.1 (Nov. 2021) states

The Board will consider, but will not routinely grant, any motion requesting to postpone a scheduled hearing date. The Board expects the parties to be ready for hearing. The representation that a settlement is imminent or probable will not guarantee a postponement. A recent change in representatives or the late filing of a motion will generally not warrant the Board granting a postponement for either party. The Board expects the parties to be diligent in planning and preparing for hearing and disfavors last minute postponement requests. Accordingly, the Board expects motions for postponement to be filed *no later than 20 days prior to hearing*, except when a party establishes good cause.

The Board notes that the postponement request was received eleven (11) days prior to the scheduled hearing. Upon review of the request, the Board finds that the Provider has *failed* to demonstrate good cause for failing to file the request no later than 20 days prior to the hearing as required by Rule 30.3.1 and therefore denies the request.

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety from this appeal. The Board also dismisses Issue 2, the Medicaid Eligible Days issue, from this appeal. Since no issues remain in the appeal, the Board closes Case No. 16-1016 and removes it from the Board's docket.

²⁴ Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

²⁵ Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by letter dated 5/5/2022); Case No. 16-2521 (by letter dated 5/5/2022); Case No. 16-0054 (by letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by letter dated 9/30/2022). Moreover, the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor (as a motion or in a position paper) well in advance of the position paper filed in this case.

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.
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Kevin D. Smith, CPA
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For the Board:

11/29/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Board Decision – SSI Percentage (Provider Specific) and Medicaid Eligible Days***
Tennova Healthcare-Clarksville (f/k/a Gateway Medical Center) (Prov. No. 44-0035)
FYE 09/30/2014
Case No. 17-1747

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“PRRB” or “Board”) reviewed the documentation in Case No. 17-1747 pursuant to a Jurisdictional Challenge filed by the Medicare Contractor (“MAC”). The Board’s decision is set forth below.

Background

A. Procedural History in Case No. 17-1747

On June 21, 2017, Tennova Healthcare-Clarksville (f/k/a Gateway Medical Center) (“Tennova” or “Provider”), appealed a Notice of Program Reimbursement (“NPR”) dated December 29, 2016, for its fiscal year end (“FYE”) September 30, 2014 cost reporting period. The Provider appealed the following issues:¹

- Issue 1: DSH SSI Percentage (Provider Specific)
- Issue 2: DSH - Medicaid Eligible Days
- Issue 3: Uncompensated Care Distribution Pool
- Issue 4: Two Midnight Census IPPS Payment Reduction

On February 20, 2018, Issues 3 and 4 were transferred to group cases.

On May 25, 2018, the Medicare Contractor filed a Jurisdictional Challenge. On October 17, 2022, the Medicare Contractor filed an updated Jurisdictional Challenge, addressing **both** remaining issues: Issue 1, the DSH SSI Percentage (Provider Specific) issue, and Issue 2, DSH – Medicaid Eligible Days.

Significantly, the Provider did not file a response to the Jurisdictional Challenge within the thirty (30) days allotted under Board Rule 44.4.3 which specifies: “Providers must file a response

¹ Provider’s Request for Hearing, Tab 3, at Issue Statement (June 21, 2017).

within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The Provider also failed to address the Jurisdictional Challenge in its final position paper.

B. Description of Issue 1 in Case Nos. 17-1747 & 16-1192GC

The Provider's appeal request in Case No. 17-1747 describes Issue 1 – DSH SSI Percentage (Provider Specific) issue as follows:

The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.

The provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ["CMS"] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

The Provider contends that the SSI percentage issued by CMS is flawed.

The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).

The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.²

As the Provider is commonly owned by Community Health Systems,³ the Provider was also directly added to the common issue related party ("CIRP") group under Case No. 16-1192GC

² Provider's Request for Hearing, Tab 3, at Issue Statement.

³ *Id.* at Model Form A – Individual Appeal Request.

entitled “Community Health Systems 2014 DSH Post 1498R SSI Data Match CIRP Group.”⁴
This CIRP group has the following issue statement:

The failure of the Fiscal Intermediary and the Centers for Medicare and Medicaid Services (CMS) to properly determine the ratio of patient days for patients entitled to Medicare Part A and Supplemental Security Income (SSI) benefits (excluding any State supplementation) to patient days for patients entitled to Medicare Part A (Medicare Proxy or Fraction) for the Provider in its Disproportionate Share Hospital (DSH) eligibility determination and payment calculation, including any related impact on capital DSH. The Provider asserts that the Medicare Proxy is improperly understated due to a number of factors, including CMS's inaccurate and improper matching or use of data along with policy changes to determine both the number of Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A patient days in the denominator, as utilized in the calculation of the Medicare percentage of low income patients for DSH purposes and/or low income patient (LIP) adjustment for Inpatient Rehabilitation Facilities (IRFs) and/or IRF units.

CMS's improper treatment and policy changes resulted in an underpayment to the Providers as DSH program eligible providers of services to indigent patients, and includes any other related adverse impact to DSH payments, such as reduced capital DSH payments or LIP adjustments. Also, this treatment is not consistent with Congressional intent to reimburse hospitals for treatment of indigent patients when determining DSH program eligibility and payment pursuant to 42 U.S.C. § 1395ww(d)(5)(F), 42 C.F.R. § 412.106, Medicare Intermediary Manual § 3610.15, or any other applicable statutes, regulations, program guidelines, or case law.

On March 22, 2006, the Provider Reimbursement Review Board (PRRB) issued a decision in the Baystate case that was favorable to the provider. The PRRB identified significant flaws in the compilation of Medicare SSI days and held, among other things, that: 1) the law requires accuracy in the reporting of SSI days; 2) the PRRB has the authority to require CMS to recalculate the SSI Percentage if necessary; and 3) there would not be a significant administrative burden required to redesign CMS's computer programs and processes to more accurately identify Medicare SSI eligibility.

The PRRBs decision was supported by the March 31, 2008, D.C. District Court decision which found CMS did not use the most

⁴ *Id.* at Model Form E with attached Schedule of Providers, received by the PRRB on June 2, 2017.

reliable data available to determine which patient days should be counted in the SSI percentage and that such was "arbitrary and capricious." The Court additionally held that if an agency has sole possession of the information needed by an opposing party to prove its claim, then it cannot simply reject the party's allegations based upon the party's lack of proof.

CMS issued Ruling 1498-R on April 28, 2010 in response to the Baystate court decision. This significant Ruling sets forth, among other things, a revised and corrected data match process CMS would use to determine Providers' appropriate Medicare proxies and overall DSH adjustments. Providers assert that errors and problems still exist in the data match process, as well as improper policy changes by CMS, which are resulting in understated DSH adjustments for Providers, including the failure to include all Dual Eligible (Medicare/Medicaid) patient days in the Medicare fraction numerator as intended by Congress or alternatively in the Medicaid fraction numerator. CMS asserts in Ruling 1498-R that such Dually Eligible/Crossover days, including such days that are Medicare Non-Covered days, are being included in the Medicare proxy for discharges occurring on or after October 1, 2004. Providers assert that all such days are not properly being captured in the Medicare proxy of the DSH and/or LIP calculation.

The estimated amount in controversy for this issue indicated in the initial appeal request in the individual Case No. 17-1747 is \$32,541. An amount in controversy was not provided for this Provider in Case No. 16-1192GC.

The Provider submitted only the cover page of its preliminary position paper and list of exhibits. However, in its final position paper filed on September 22, 2022, the Provider asserts the following with regard to Issue 1:

Calculation of the SSI Percentage

The Provider contends that the MAC's determination of the Medicare Reimbursement for DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider contends that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of

Tennessee and the Provider does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Tennessee and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.

The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review (“MEDPAR”) database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its’ SSI percentage based on CMS’s admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.⁵

The only exhibit included with the final position paper that relates to Issue 1 was Exhibit 2, which shows that the estimated amount in controversy, which is the same amount as was listed in the initial appeal request. The amount in controversy for this Provider was not provided in the appeal request for 16-1192GC.

MAC’s Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC contends that the portion of Issue 1 concerning SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment, should be dismissed because it is duplicative of the issue in Group Case No. 16-1192GC, *Community Health Systems 2014 DSH Post 1498R SSI Data Match CIRP Group*, to which the Provider was directly added. The MAC asserts that Board Rule 4.6.1 prohibits a provider from appealing the same issue from a single determination in more than one appeal.⁶

With respect to the portion of Issue 1 concerning realignment, the MAC asserts that it should also be dismissed because the Provider abandoned this portion of the issue by not briefing it in its preliminary position paper as required by Board Rule 25.3. In addition, the MAC asserts that there was no final determination over SSI realignment and the Provider’s appeal is premature as the Provider has not exhausted all available remedies.⁷

⁵ Provider’s Final Position Paper, at 8-9 (Sept. 22, 2022).

⁶ MAC’s Jurisdictional Challenge, at 2, 4-6.

⁷ *Id.* at 2, 6-7. The MAC also notes that the Provider’s fiscal year end is the same as the federal fiscal year end, and therefore the Medicare computation based on the Provider’s fiscal year end would be the same as the Medicare computation based on the federal fiscal year end.

Lastly, the MAC asserts that Issue 1 should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.⁸

Issue 2 – DSH – Medicaid Eligible Days

The MAC contends that the Provider has abandoned this issue because it has not submitted a list of additional Medicaid days. The MAC further explains that the Provider has essentially abandoned the issue by failing to properly develop its arguments or to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules. Therefore, the MAC requests that the Board dismiss this issue.⁹

Provider’s Response:

The Provider did not file a response to the Jurisdictional Challenge. Moreover, the final position paper even failed to address the original 2018 Jurisdictional Challenge. As previously noted, Board Rule 44.4.3 specifies: “Providers must file a response within thirty (30) days of the Medicare contractor’s jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.

Board Analysis

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), 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 (or \$50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Provider Specific

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

1. First Aspect of Issue 1

The first aspect of Issue 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Data Match issue in PRRB Case No. 16-1192GC, *Community Health Systems 2014 DSH Post 1498R SSI Data Match CIRP Group*.

⁸ *Id.* at 2, 7-10.

⁹ *Id.* at 11-13.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of the group issue in Case No. 16-1192GC. The first aspect of Issue 1 in the present appeal concerns “whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation.”¹⁰ The Provider’s legal basis for this aspect of Issue 1 is simply that the Medicare Contractor “did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i).”¹¹ Similarly, the Provider argues that “it[s] SSI percentage published by [CMS] was incorrectly computed . . .” and it “. . . [s]pecifically . . . disagrees with the MAC’s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary’s Regulations.”¹² The SSI Data Match issue in Case No. 16-1192GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, which was not in accordance with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 16-1192GC, for this same provider and same fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (July 1, 2015), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not “specific” to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 16-1192GC. Further, any alleged “systemic” issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.¹³ The Provider is misplaced in referring to Issue 1 as “Provider Specific” and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged “provider specific” errors can be distinguished from the issue, rather than being subsumed into the issue, appealed in Case No. 16-1192GC.

To this end, the Board also reviewed the Provider’s Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 16-1192GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider’s Final Position Paper failed to comply with Board Rule 27.2 governing the content of position papers, which refers to the content more specifically described in Board Rule 25 for Preliminary Position Papers. As explained in the Commentary to Rule 23.3, the Board requires position papers “to be **fully** developed and include **all available** documentation necessary to provide a *thorough understanding* of the parties’ positions.” Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged “errors” in its Final Position Paper and include *all* exhibits.

¹⁰ Provider’s Request for Hearing, Tab 3, at Issue Statement, Issue 1.

¹¹ *Id.*

¹² *Id.*

¹³ The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. See *Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, “[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital’s patients eligible for both SSI and Medicare at the hospital’s request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital’s fiscal year differs from the Federal fiscal year, for the **months included in the 2 Federal fiscal years that encompass the hospital’s cost reporting period.*** Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year.* The data set made available to hospitals will be the **same data set** CMS uses to calculate the Medicare fractions for the Federal fiscal year. Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from CMS and in some cases on a self-service basis as explained on the following webpage:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.¹⁴
This CMS webpage describes access to DSH data **from 1998 to 2017** as follows: “DSH is now a self-service application. This **new self-service process** enables you to enter your data request(s) and retrieve your data files through the CMS Portal.”¹⁵

¹⁴ (Last accessed Nov. 21, 2022.)

¹⁵ (Emphasis added.)

Accordingly, the Board must find that Issue 1 and the group issue in Case No. 16-1192GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis, the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with the Board Rules.

2. Second Aspect of Issue 1

While the Provider indicates in its Appeal Request that Issue 1 includes the realignment sub-issue, the Provider's Final Position Paper does not mention this sub-issue. Further, the Provider's cost reporting year is the same as the federal fiscal year, and therefore, realignment would have no effect.

Nonetheless, the second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, “[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request” Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment as such there is no “determination” to appeal and the appeal of this issue is otherwise premature.

B. DSH Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider states Issue 2 as:

Statement of the Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital (“DSH”) calculation.

Statement of the Legal Basis

The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.

The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after

the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.¹⁶

The amount in controversy calculation and protested item documentation for this issue suggests that there are 150 Medicaid eligible days at issue. However, the Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desired to be included in their Medicaid percentage and DSH computations.

On February 20, 2018, the Provider filed its preliminary position paper and only provided the cover page and a list of exhibits without the exhibits themselves.

On September 22, 2022, the Provider filed its final position paper in which it indicated it would be sending its eligibility listing under separate cover.¹⁷ Based on the calculation of the amount in controversy provided in Exhibit 2, it appears that 150 days remained at issue. The Provider's complete briefing of this issue in its position paper is as follows:

Calculation of Medicaid Eligible Days

Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).

[CMS], formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

[T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction,

¹⁶ Provider's Request for Hearing, Tab 3, at Issue Statement, Issue 2.

¹⁷ Provider's Final Position Paper, at 8, 10.

whether or not the hospital received payment for these inpatient hospital services.

Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2014 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.¹⁸

In its jurisdictional challenge, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days with either its preliminary or final position papers, even though the Provider advised that a list was being sent under separate cover in both filings.¹⁹

Board Rule 7.3.1.2 (Nov. 2021) states:

No Access to Data

If the Provider elects not to claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

Moreover, the MAC asserts that pursuant to Board Rule 25.3, parties should file a complete preliminary position paper with a fully developed narrative, *all exhibits*, a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853.²⁰ Here, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.²¹

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary or final position papers or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.²²

42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

(2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper *must set forth the relevant facts* and arguments *regarding* the Board's jurisdiction

¹⁸ *Id.* at 7-8.

¹⁹ MAC's Jurisdictional Challenge, at 10.

²⁰ *Id.* at 11 (emphasis in original).

²¹ *Id.*

²² *Id.* at 11-13.

over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue.*

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions.*²³

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Jul. 2015) states:

If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Similarly, with regard to position papers,²⁴ Board Rule 25.2.1 requires that “the parties must exchange *all* available documentation as exhibits to fully support your position.”²⁵ This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Also consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.²⁶

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

²³ (Emphasis added.)

²⁴ The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. See PRRB Rule 27.2.

²⁵ (Emphasis added).

²⁶ (Emphasis added).

The hospital has *the burden of furnishing data adequate to prove eligibility* for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.²⁷

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures,
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

The Board concurs with the Medicare Contractor that the Provider is required *both* to identify *and* provide documentation to establish what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. This information and documentation is needed to establish the facts material to this issue. Moreover, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof “to prove eligibility for *each* Medicaid patient day claimed”²⁸ and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation in its Final Position Paper (or any other filing) as to why the documentation was absent or what is being done to obtain it, consistent with Board Rule 25.2.2.

The Board finds that the number and identification of Medicaid eligible days at issue in this case are material facts and that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. In particular, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.A and 25.2.B (2015)

²⁷ (Emphasis added.)

²⁸ (Emphasis added.)

for the preliminary position paper, and Board Rules 25.2.1 and 25.2.2 (2021) for the final position paper, related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.²⁹ The hearing in this case is scheduled for December 16, 2022 and, yet, even at this late date (more than 6 years after this appeal was filed), the Provider has not included any of this critical material information in the record. In short, the Provider has failed to establish the merits of this issue as part of the position paper briefing process. Accordingly, the Board dismisses the Medicaid Eligible Days issue pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b). The Board takes administrative notice that it has made similar dismissals in other cases in which QRS was the designated representative and, notwithstanding, QRS filed to provide the Medicaid eligible days listing with its final position paper.³⁰

Decision

The Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 16-1192GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers. The Board also dismisses the Medicaid eligible days issue as the Provider also failed to meet the Board requirements for position papers for this issue. As no issues remain pending, the Board hereby closes Case No. 17-1747 and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/29/2022

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Cecile Huggins, Palmetto GBA

²⁹ Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2. The preliminary position paper was filed on February 20, 2018, so the Board Rules version 1.3, effective July 1, 2015 apply.

³⁰ Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by letter dated 5/5/2022); Case No. 16-2521 (by letter dated 5/5/2022); Case No. 16-0054 (by letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by letter dated 9/30/2022).



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Jesse Carter
Senior Financial Analyst, Reimbursement Services
Fortis Management Group, LLC
111 West Michigan Street
Milwaukee, WI 53203-2903

RE: Notice of Dismissal
Extendicare Homes 2013 Sequestration Calculation Challenge CIRP Group
Case No. 15-3304GC

Dear Mr. Carter:

You are the representative in the above-referenced case relating to the Hospice Sequestration issue pending on the Provider Reimbursement Review Board's ("PRRB" or "Board") docket.

Upon written notice from the group representative, the Board will deem a group fully formed. Absent written notice from the group representative, the Board may issue an Order requiring the group representative to provide proof of why the group case should not be deemed fully formed.¹

On October 27, 2022, the Board sent a Request for Group Status letter to determine if this CIRP group was fully formed because no providers had been added since February 23, 2016. In the same Request for Group Status, you were informed that failing to timely respond to the Board's request would result in the dismissal of the CIRP group appeal.

To date, the Board has received no communication in response to its October 27, 2022 Request for Group Status. Accordingly, pursuant to Board Rule 41.2,² the Board dismisses this CIRP group appeal because the Provider has failed to respond to the Request for Group Status within the Board's deadline.

¹ 42 C.F.R. § 405.1837(e) – "Absent such a notice from the group, the Board may issue an order, requiring the group to demonstrate (within a period of not less than 15 days) that at least one commonly owned or controlled provider has preserved the issue for appeal by claiming the relevant item on its cost report or by self-disallowing the item, but has not yet received its final determination with respect to the item for a cost year that is within the same calendar year as that covered by the group appeal (or that it has received its final determination with respect to the item for that period, and is still within the time to request a hearing on the issue)."

² Rule 41.2 Own Motion – "The Board may dismiss a case or an issue on its own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868). . . ."

This CIRP group appeal is hereby closed.

Board Members Participating:

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

FOR THE BOARD:

11/30/2022

X Robert A. Evarts, Esq.

Robert A. Evarts, Esq.

Board Member

Signed by: Robert A. Evarts -A

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Wilson Leong, Federal Specialized Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision – SSI Realignment***

14-3292GC Cleveland Clinic 2010 SSI Fraction Medicare Advantage Days CIRP Group
14-3296GC Cleveland Clinic 2010 Medicaid Fraction Medicare Advantage Days CIRP Grp.

Dear Ms. Goron and Ms. Cummings:

The Provider Reimbursement Review Board (“PRRB” or “Board”) reviewed the jurisdictional documentation in the common issue related party (“CIRP”) groups under Case Nos. 14-3292GC and 14-3296GC. The Board’s decision is set forth below.

Background

The group appeal requests were initially filed on April 23, 2014. Additional providers were added to the groups, including one Participant in each group requesting to be directly added to the groups from revised Notices of Program Reimbursement (“NPR”):

Case No. 14-3292GC – Euclid Hospital (Prov. No. 36-0082, FYE 12/31/2010)

- Notice of Reopening and Adjustment No. 1 note that the adjustment was to recalculate the SSI% based on SSI realignment.¹

Case No. 14-3296GC – Huron Hospital (Prov. No. 36-0101, FYE 12/31/2010)

- Notice of reopening: “To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider’s request received 11/09/2016.”²

Board’s Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2017), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is \$10,000 or more (\$50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

¹ See Notice of Reopening (Dec. 4, 2019), Case No. 14-3292GC. See Audit Adjustment Report, Prov. No. 36-0082.

² See Notice of Reopening, Provider No. 36-0101 (Nov. 14, 2016), PRRB Case no. 14-3296GC.

The Code of Federal Regulations provides for an opportunity for a reopening and revised NPR at 42 C.F.R. § 405.1885 (2014), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2014) explains the effect of a cost report revision:

(a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

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

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

42 C.F.R. § 405.1835(a) explains a provider's right to appeal to the Board and specifically references § 405.1889:

(a) *Right to hearing on final contractor determination.* A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -

(1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception:** If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in**

the contractor's revised final determination (§§ 405.1887(d), 405.1889(b), and the “Exception” in § 405.1873(c)(2)(i)).³

As described below, the Board finds that it does not have jurisdiction over the participants that filed from a revised NPR, because the revised NPRs were issued as a result of the Providers’ SSI Realignment requests, and did not adjust the Part C days.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to “[o]nly those matters that are specifically revised[.]”⁴ The reopening in this case was a result of the Provider’s request to realign their SSI percentage from the federal fiscal year end to their individual cost reporting fiscal year end. The audit adjustments associated with the revised NPR under appeal clearly revised the SSI percentage in order to realign it from a federal fiscal year to the provider’s respective fiscal year. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider’s request for realignment of its SSI percentage.

As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

(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

(B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).⁵

³ (Emphasis added.)

⁴ 42 C.F.R. § 405.1889(b)(1).

⁵ (Emphasis added.)

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.⁶ As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—“[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.*”⁷
2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—“Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital must accept the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year.* . . .

Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period.* Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year.* The data set made available to hospitals will be the *same data set* CMS uses to calculate the Medicare fractions for the Federal fiscal year.”⁸

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g.*, Part C days or Part A days) because that data had been previously gathered on a month-by-month basis and *there is no need for CMS to rerun the data matching process* in order to effectuate a realignment (*i.e.*, realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider “must accept” the realigned SSI percentage.

⁶ 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).

⁷ (Emphasis added.)

⁸ (Emphasis added.)

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the RNPR appeal of the DSH Part C days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.⁹

The Board further notes that Euclid Hospital is not prejudiced by the dismissal of its RNPR appeal because it remains a participant in the groups based on the appeal of the Part C days issue from its original NPR. However, unlike Euclid Hospital, Huron Hospital had the opportunity to appeal this issue from the original NPR issued for FY 2010 but apparently forewent its opportunity.

In conclusion, the Board is dismissing two participants, namely Euclid Hospital (Prov. No. 36-0082, FYE 12/31/2010) in Case No. 14-3292GC and Huron Hospital (Prov. No. 36-0101, FYE 12/31/2010) in Case No. 14-3296GC, because they do not have the right to appeal the revised NPRs at issue under 42 C.F.R. § 405.1889 for the DSH Part C days issue. The remaining providers in both cases will be remanded pursuant to CMS Ruling 1739-R under separate cover.¹⁰

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

Board Members Participating:

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For the Board:

11/30/2022

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

⁹ See *St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, 464 F. Supp. 3d 1 (D.D.C. 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

¹⁰ Note that Euclid Hospital (Prov. No. 36-0077) has an original NPR that is still under appeal, for the same fiscal year and, as such, remains a participant based on the original NPR appeal.