DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination***
20-0203GC Banner Health FY 2017 DGME Fellowship Penalty Group

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' November, 2019 request for expedited judicial review ("EJR") (received November 5, 2019). The decision of the Board is set forth below.

The issue for which EJR is requested is:

> . . .the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Providers assert that] the regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the statute because it determines the cap after application of weighting factors.[1]

Background

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

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

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and

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

3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[5]

This appeal concerns the first component of the DGME payment calculation—the resident FTE count.

The Medicare Statute

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

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
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> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

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

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

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or

[5] 42 U.S.C. § 1395(h).
[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

> 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

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

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

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

[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

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

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

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

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[13] This regulation is the focus of these appeals and this EJR request, and it states the following:

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

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

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

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

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

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

The Providers' Position

The Providers assert that the MAC's calculations of the current, prior-year and penultimate-year DGME FTEs and the FTE caps are contrary to the statutory provisions at 42 U.S.C.

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

§ 1395ww(h), and, as a result , the Providers' DGME payments are understated. The Providers contend that the regulation implementing the cap and the weighting factors is contrary to the statute because it determines the cap after the application of the weighting factors.[17] The effect of this regulation is to impose on the Providers weighting factors that result in reductions greater than 0.5 for many residents who are beyond the IRP, and the regulation prevents the Providers from claiming and receiving reimbursement for their full unweighted FTE caps.[18]

The Providers explain that the Medicare statute caps the number of residents that a hospital can claim at the number it trained in cost years ending in 1996.[19] The statute states that, for residents beyond the IRP, "the weighting factor is .50."[20] The statute also states that the current year FTEs are capped before application of the weighting factors: "the total number of full-time equivalent residents before application of the weighting factors . . . may not exceed the number . . . of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996."[21] The Providers conclude that this statutory scheme sets an absolute weighting factor on fellows of 0.5 and requires that the weighting factors are not applied when capping the current year FTEs.

The Providers claim that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[22] Instead, a weighted FTE cap is determined for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE(UCAP/UFTE) = WCap,[23] is applied to the weighted FTE count in the current year which creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Providers contend that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[24]

Second, the Providers posit, the weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The Providers explain that the downward impact on the FTE count increases as hospital trains more residents beyond the IRP and the problem increase as a hospital trains more fellows because the methodology amplifies the reduction.

Third, in some situations, as demonstrated by the Table on page 12 of the Providers' EJR request, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Providers point out that the cap was established based on the hospital's

[17] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[18] 42 C.F.R. § 413.79(c)(2).
[19] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[20] *Id.* at § 1395ww(h)(4)(C)(iv).
[21] *Id.* at 1395ww(h)(4)(F)(i).
[22] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[23] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[24] *Id.* at §1395(h)(4)(F)(i).

unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.

The Providers conclude that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion. Since, the Board lacks the authority to grant the relief sought, the request for EJR should be granted.

Decision of the Board

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

A. Compliance with requirements for filing a Board appeal

The Providers in this case are appealing based on the Medicare Contractor's failure to issue a timely final determination under the provisions of 42 C.F.R. § 405.1835(c). This regulation permits a provider to file an appeal with the Board where:

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's *perfected cost* report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .[25]

The Providers' documentation demonstrates that the timely filing requirements of the regulation have been met and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[26] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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[25] (Emphasis added).
[26] *See* 42 C.F.R. § 405.1837.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873

The Providers appealed from the Medicare Contractors failure to time issue a final determination for covering cost reporting periods ending December 31, 2017, and are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[27] Specifically, effective for cost reporting periods beginning on or after January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[28]

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"[29] 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.[30] As no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[31] 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.[32] As a

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[27] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").

[28] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.

[29] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

[30] *See* 42 C.F.R. § 405.1873(a).

[31] 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."

[32] Although no question was raised in this appeal regarding whether an appropriate claim was made, the record suggests that the Providers complied with the requirements of 42 C.F.R. § 413.24(j) given that: (1) the jurisdictional documents accompanying the EJR request include, under Tab D for each of the providers in this appeal, a summary of the protested amounts that appears to have been filed with the relevant cost report; and (2) each of these summaries includes a claim for "DGME penalty issue" along with a worksheet detailing the proposed DMGME reimbursement calculation. Further, the Board notes that each of the providers in this appeal filed their appeals based on the Medicare Contractor's failure to issue a final determination within 12 months of the receipt of the Providers' cost reports and, as such, there is no final determination and, in particular, no adjustment of these protested amounts.

result, compulsory Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board's Analysis of the Appealed Issue

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

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

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[34] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[35] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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

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[33] EJR Request at 4.
[34] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[35] 66 Fed. Reg. at 39894 (emphasis added).

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

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[37] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[38] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[39] (*i.e.*, ratios) using variables a, b, c, and d:

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

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

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[36] (Emphasis added.)
[37] *See* 62 Fed. Reg. at 46005 (emphasis added).
[38] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).
[39] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.
[40] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

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

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

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

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

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

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

D. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

12/3/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

Enclosures: Schedule of Providers

cc: John Bloom, Noridian Healthcare Solutions
Wilson Leong, FSS

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401 9th Street, N.W.
Washington, DC 20004

RE: ***Board Own Motion Expedited Judicial Review Determination***
Part C Days Medicaid and Medicare Proxy Groups and Individual Appeals

08-2067GC	UHS 2005 Medicare Managed Care Days CIRP
09-1337	Bella Vista Hospital (Provider No. 40-0014, FYE 12/31/2005)
08-1384	Hospital de la Concepcion (Provider No 40-0021, Period 10/1/2004-12/31/2004)
09-0433	Hospital Daman, Inc (Provider No 40-0022, FYE 12/31/2005)
08-0889	Hospital Buen Samaritano (Provider No 40-0079, Period 10/1/2004-12/31/2004)
09-0374	Hospital San Carlos Corromeo (Provider No 40-0111, FYE 12/31/2005)
09-1959	Hospital San Carlos Corromeo (Provider No 40-0111, FYE 12/31/2006)
09-1113	Hospital Wilma N. Vazquez (Provider No 40-0115, FYE 12/31/2005)
10-0217	Hospital Wilma N. Vazquez (Provider No 40-0115, FYE 12/31/2006)

Dear Mr. Roth:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced appeals and, on August 2, 2019, as required by 42 C.F.R. § 405.1842(c), notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above-referenced cases. The Board notes that the Providers and Federal Specialized Services ("FFS"), on behalf of the Medicare Contractor, have submitted comments as to whether the Board is without the authority to decide the following legal question[1]:

> Whether the Hospitals' Medicare DSH payments starting on October 1, 2014 were understated because (a) the numerator of the Medicaid fraction improperly excluded inpatient hospital days attributable to dually-eligible Medicare Part C plan enrollee patients and (b) the Medicare/SSI fraction improperly included inpatient hospital days attributable to Medicare Part C enrollee patients…[2]

[1] FSS's comments were received on September 2, 2019, and Providers' comments were received on September 3, 2019.
[2] Providers' Consolidated Response to Notice of Board's Own Motion Consideration of Whether EJR is Appropriate, at 2 (Sep. 3. 2019), PRRB Case No. 08-2067GC.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[10]

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

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[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] Emphasis added.
[11] 42 C.F.R. § 412.106(b)(2)-(3).

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[13]

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[14] stated that:

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

[12] Emphasis added.
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.

> including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[18]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[19]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[20] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits*

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[15] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[16] *Id.*
[17] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[18] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[20] 69 Fed. Reg. at 49099.

> *under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[21]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[22] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[23] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[24]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[25] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[26] However, the Secretary has not acquiesced to that decision.

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] *Id*. at 47411.
[24] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F. 3d 1102 (D.C. Cir. 2014).
[26] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[28] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[29] Once again, the Secretary has not acquiesced to this decision.

Board's Consideration for Own Motion EJR

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[30] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[31] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the regulation announced in the FFY 2005 Final Rule that the Board lacks the authority to grant. The Providers maintain that, since the Secretary has not acquiesced to the decision in *Allina I*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

[27] 863 F.3d 937 (D.C. Cir. 2017).
[28] *Id.* at 943.
[29] *Id.* at 943-945.
[30] 69 Fed. Reg. at 49,099.
[31] *Allina* at 1109.

Jurisdiction

The participants addressed in this own-motion EJR determination have filed appeals involving fiscal years (or portion thereof[32]) 2004 through 2006.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[33] 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.[34]

The Board has determined that the participants' appeals involved with the instant own-motion EJR are governed by the decision in *Bethesda*. Each Provider appealed from an original NPR. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal[35] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the referenced appeals and the participants.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the fiscal years (or portion thereof[36]) 2004 through 2006 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[37] Moreover, the

[32] The Providers in Case Nos. 08-1384 and 08-0889 each have a fiscal year ending December 31, 204. For purposes of this EJR decision, the Part C days issue in Case Nos. 08-1384 and 08-0889 ***only*** involves *the last quarter* of the fiscal year (*i.e.*, 10/01/2004 to 12/31/2004) because, pursuant to the FY 2005 IPPS Final Rule, the Part C days policy at issue in this EJR decision was effective October 1, 2004.
[33] 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.).
[34] *Bethesda*, 108 S. Ct. at 1258-59.
[35] *See* 42 C.F.R. § 405.1837.
[36] *See supra note* 32.
[37] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C.

D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[38] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

Board's Decision Regarding the Own Motion EJR

The Board finds that:

1) It has jurisdiction over the matter for the subject years[39] and that the participants in the individual appeals are entitled to a hearing before the Board;

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

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants its Own Motion EJR for the issue and the subject years. The participants 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 remaining in these cases, the Board hereby closes those cases.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

12/4/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

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

Enclosure: Schedule of Providers for 08-2067GC

Cir. 2017).
[38] *See* 42 U.S.C. § 1395oo(f)(1).
[39] *See supra* note 32.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination Hall Render DSH Dual Eligible SSI Patient Days Groups***

14-3234GC	Baptist Health Arkansas 2011 Medicare Fraction Dual Eligible Days Grp
15-1008GC	WakeMed 2010 DSH SSI Fraction Dual Eligible Days Group
15-1106GC	Advocate Health 2010 DSH SSI Ratio Dual Eligible Days Group
15-2091GC	WakeMed 2011 DSH SSI Fraction Dual Eligible Days Group
15-3327GC	Valley Health 2011 DSH SSI Fraction Dual Eligible Days Group
16-1791GC	WakeMed 2009 DSH Medicare Fraction Dual Eligible Days Group
16-2020GC	Advocate 2009 DSH Medicare Fraction Dual Eligible Days Group
17-1788GC	Baptist Health (Arkansas) 2012 SSI Dual Eligible Days Group
17-2175GC	WakeMed 2012 DSH SSI Fraction Dual Eligible Days Group
18-0043GC	Baptist Health (Arkansas) 2013 DSH SSI Dual Eligible Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' November 1, 2019 request for expedited judicial review ("EJR") (received November 4, 2019) in the above-referenced appeals. The Board's decision with respect EJR is set forth below.

Issue in Dispute

The issue for which the Board is considering EJR is:

> [W]hether the Providers' Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI

> Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[1]

Medicare Disproportionate Share Hospital (DSH) Payment Background

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

> (2) *First computation: Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
> (i) Determines the number of patient days that –
> (A) Are associated with discharges occurring during each month; and
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
> (ii) Adds the results for the whole period; and
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
> (A) Are associated with discharges that occur during that period; and
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[4]

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

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[1] Providers' EJR Request at 2.
[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[4] (Bold emphasis added and italics emphasis in original.)

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[5] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[6] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[7]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[8] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[9]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[10] and may terminate,[11] suspend[12] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[13] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[14]
2. The individual fails to apply for other benefits to which the individual may be entitled;[15]
3. The individual fails to participate in drug or alcohol addiction treatment;[16]
4. The individuals is absent from the United States for more than 30 days;[17] or
5. The individual becomes a resident of a public institutions or prison.[18]

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[5] 42 U.S.C. § 1382.
[6] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[7] 20 C.F.R. § 416.202.
[8] 42 U.S.C. § 426.
[9] 42 U.S.C. § 426-1.
[10] 20 C.F.R. § 416.204.
[11] 20 C.F.R. §§ 416.1331-1335.
[12] 20 C.F.R. §§ 416.1320-1330.
[13] 20 C.F.R. § 1320.
[14] 20 C.F.R. § 416.207.
[15] 20 C.F.R. § 416.210.
[16] 20 C.F.R. § 416.214.
[17] 20 C.F.R. § 416.215.
[18] 20 C.F.R. § 416.211.

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[19]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[20] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[21] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[22] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[23] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[24]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[25]

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[19] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[20] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[21] *Id.*
[22] *Id.*
[23] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[24] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[25] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[26] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[27] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[28]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[29] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[30]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[31] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data

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individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.*, Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[26] CMS-1498-R at 5.

[27] *Id.*

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

[29] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

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

[31] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

match process."[32] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[33] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[34] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[35]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e*., for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[36] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[37] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[38]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[39]

As a result of the Rulings, new regulation and data match process, CMS either calculated new SSI percentages or recalculated existing SSI percentages for each of the Providers for all of fiscal

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[32] *Id.* at 50280.
[33] *Id.* at 50280-50281.
[34] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[35] *Id.* at 50285.
[36] CMS-1498-R at 6-7, 31.
[37] *Id.* at 28, 31.
[38] 75 Fed. Reg. at 24006.
[39] CMS-1498-R2 at 2, 6.

years at issue in these appeals.[40] All of the Providers in the groups covered by this EJR decision have appealed from *original* NPRs that used SSI percentages calculated based on the methodology articulated in the preamble to the FY 2011 IPPS Final Rule which includes using only the three SSI codes to denote SSI entitlement under 42 C.F.R. § 412.106(b)(2).

Providers' Request for EJR

The Providers assert that, under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, over time, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the numerator of the Medicare fraction in the DSH calculation, an SSI enrollee must actually have received a cash payment from SSA for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[41]

The Providers note that, in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the statutory provisions governing the DSH calculation.[42] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for *or* entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the Medicare statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' DPP calculations to which they are entitled pursuant to § 951 of the Medicare Prescription Drug, Improvement and Modernization Act.[43]

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[40] The SSI ratios for FY 2009 and 2010 were published on March 16, 2012 and October 17, 2012, respectively. *See* https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[41] 75 Fed. Reg. at 50275-286.
[42] *Id.* at 50281.
[43] Pub. L. No. 108-173, § 951, 117 Stat. 2066, 2427 (2003).

Decision of the Board

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

A. Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2009-2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending *prior to December 31, 2008*, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[44] 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.[45]

On August 21, 2008, new regulations governing the Board were effective.[46] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[47] 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.[48]

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[44] 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.).
[45] *Bethesda* at 1258-59.
[46] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[47] 201 F. Supp. 3d 131 (D.D.C. 2016)
[48] *Banner* at 142.

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 ("Ruling 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 Ruling 1727-R, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest. The Board finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. Consequently, the Board finds that it has jurisdiction over the Providers in these cases.

The Board has determined that the participants involved with the instant EJR request are governed by Ruling 1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[49] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued Ruling 1498-R on April 28, 2010 to authorize remands of pending appeals of the SSI data match issue in order to recalculate the associated SSI fractions based on a revised data match process.[50] The Secretary also stated in the Ruling that, for those hospitals whose cost reports had not yet been settled, the Secretary would recalculate the SSI fractions for those cost reports using the revised data match process to be published through rulemaking.[51] Contemporaneous with Ruling 1498-R,[52] the Secretary published a proposed IPPS rule[53] to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the FY 2011 IPPS Final Rule in which the Secretary explained that:

> . . .we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed

[49] *See* 42 C.F.R. § 405.1837.
[50] CMS Ruling 1498-R at 27.
[51] *Id.* at 31.
[52] *Id.* at 5.
[53] 75 Fed. Reg. 23852, 24002-07.

> using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[54]

Then she further announced:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[55]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[56]

While the Secretary did not incorporate the above new policy involving the revised data match process directly into the Code of Federal Regulations, it is clear from the language in the preamble to the FY 2011 IPPS Final Rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a binding data match process to be used by CMS in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2).

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[57] Moreover, it is clear that the Uncodified SSI Data Match Regulation

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[54] 75 Fed. Reg. at 50277.
[55] (Medicare) Enrollment Database.
[56] 75 Fed. Reg. at 50285.
[57] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation the published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility.[58] As a result, the Board finds that EJR is appropriate for the issue for the calendar years under appeal in these cases.

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule 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 authority to decide the legal question of whether the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to

[58] The Board notes that the majority of the cases involve fiscal years beginning on or after October 1, 2010 and, as such, Ruling 1498-R is not applicable or relevant to the majority of the cases. However, there are a subset of cases that involve Ruling 1498-R (*see, e.g.*, Case Nos. 15-1008GC, 15-1106GC, 16-1791GC, and 16-2020GC) where the providers had a pre-10/1/2010 open cost report when Ruling 1498-R was issued and appealed from an original NPR. Notwithstanding, the Board notes that the Providers in this subset have *only* disputed the validity of the Uncodified SSI Data Matching Regulation which is applied to them via Ruling 1498-R as confirmed in the preamble to the FY 2011 IPPS Final Rule (75 Fed. Reg. at 50824-25) and have ***not*** raised any disputes or issues regarding the validity of Ruling 1498-R itself. *See* EJR request (including references to the Board's June 1, 2018 EJR determination in Case Nos. 13-10678, *et al*.); *compare* group appeal requests for all group appeals covered by this EJR decision. Accordingly, the Board finds that there are no substantive factual or legal differences among the cases covered by this EJR decision that would otherwise require the Board to bifurcate this EJR decision.

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

Board Members Participating:

Clayton J. Nix, Esq.
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FOR THE BOARD:

12/4/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Justin Lattimore, Novitas Solutions
Danene Hartley, NGS
Laurie Polson, Palmetto GBA
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Expedited Judicial Review Determination***
HRS Franciscan Missionaries of Our Lady Health System (FMOLHS) Part C Days Proxy Grps
16-1744GC HRS FMOLHS 2013 DSH SSI Fraction Medicare Mnagd Care Part C Days CIRP
16-1745GC HRS FMOLHS 2013 DSH Medicaid Fractn Medicare Mngd Care Part C Days CIRP

Dear Ms. Goron:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' November 8, 2019, Requests for Expedited Judicial Review ("EJR") of the above referenced appeals. The Board's jurisdictional determination and decision regarding the EJR requests is set forth below.

Issue in Dispute

The relevant issue in these appeals is:

> The Providers contend that the Medicare Administrative Contractor's ("MAC") treatment of the MA days is not in accordance with the DSH statute at 42 U.S.C § 1395ww(d)(5)(F)(vi)(II). The MACs failed to include patient days applicable to MA patients who were also eligible for Medicaid in the Medicaid fraction of the Medicare DSH payment adjustment, but instead included those days in the SSI or Medicare fraction.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] Request for Expedited Judicial Review Determination, Issue Statement, at 1 (Nov. 8, 2019), 16-1744GC; *See also id*. at PRRB Case 16-1745GC.

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

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

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[9]

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

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical

[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] Emphasis added.
[10] 42 C.F.R. § 412.106(b)(2)-(3).

> assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[11]

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

Medicare Advantage Program

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

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

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

[11] Emphasis added.
[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services.
[14] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

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

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

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[18]

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

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

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[15] *Id.*

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

[17] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[18] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[19] 69 Fed. Reg. at 49099.

> *stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[20]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[21] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[22] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[23]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[24] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[25] However, the Secretary has not acquiesced to that decision.

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[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] *Id*. at 47411.
[23] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

More recently, in *Allina Health Services v. Price* ("*Allina II*"),[26] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[27] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[28] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[29] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[30] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the regulation announced in the FFY 2005 Final Rule that the Board lacks the authority to grant. The Providers maintain that since the Secretary has not acquiesced to the decision in *Allina I*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.
[29] 69 Fed. Reg. at 49,099.
[30] *Allina* at 1109.

Jurisdiction

The participants addressed in this EJR determination have filed appeals involving fiscal year 20132 (FYE's ending prior to October 1, 2013).

On August 21, 2008, new regulations governing the Board were effective.[31] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[32] 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.[33]

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

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[34] The appeals were timely filed.[35] Based on the above, the Board finds that it has jurisdiction for the

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[31] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[32] 201 F. Supp. 3d 131 (D.D.C. 2016).
[33] *Id.* at 142.
[34] *See* 42 C.F.R. § 405.1837.
[35] #2 Our Lady of Lourdes Regional Medical Center (Provider No. 19-0064); and #3 St. Francis Medical Center (Provider No. 19-0102) filed appeals that are dated 188 days from the receipt of their respective NPRs. The NPRs are presumed to have been received 5 days after the date of issuance by the Medicare Administrative Contractor. Although the hearing requests for the above referenced Providers were received (filed) more than 185 days after the presumed date of receipt of the NPRs as required by 42 C.F.R. § 405.1835(a)(3), the due date (*i.e.*, day 185) fell on a Saturday and, as such, the due date is moved to the following business day. As Monday, May 30, 2016 was a holiday, Memorial Day, the next business day was Tuesday, May 31, 2016 (*i.e.*, Day 188). This is the date the appeals were received by the Board. Therefore, for these providers, Day 188 is considered timely filing of these appeals, and jurisdiction is valid.

above-captioned appeals and the remaining underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the fiscal year 2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[36] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[37] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

Board's Decision Regarding the EJR

The Board finds that:

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

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

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the EJR for the issue and the subject years. The participants have 60 days from the

[36] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[37] *See* 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

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For the Board:

12/4/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, Federal Specialized Services
Justin Lattimore, Novitas Solutions, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination - DSH Dual Eligible SSI Patient Days***
Dell Seton Medical Center at the University of Texas (Provider No. 45-0124)
FYE 6/30/2007
Case No. 19-1511

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' November 5, 2019 request for expedited judicial review ("EJR") (received November 6, 2019) in the above-referenced appeal. The Board's decision with respect to jurisdiction and EJR is set forth below.

Issue in Dispute

The issue for which the Board is considering EJR is:

> [W]hether the Providers' Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[1]

Medicare Disproportionate Share Hospital (DSH) Payment Background

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment

[1] Provider's EJR Request at 2.

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

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
> (i) Determines the number of patient days that –
> (A) Are associated with discharges occurring during each month; and
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
> (ii) Adds the results for the whole period; and
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
> (A) Are associated with discharges that occur during that period; and
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[4]

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

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[5] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[6] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or

[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[4] (Bold emphasis added and italics emphasis in original.)
[5] 42 U.S.C. § 1382.
[6] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).

disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[7]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[8] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[9]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[10] and may terminate,[11] suspend[12] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[13] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[14]
2. The individual fails to apply for other benefits to which the individual may be entitled;[15]
3. The individual fails to participate in drug or alcohol addiction treatment;[16]
4. The individuals is absent from the United States for more than 30 days;[17] or
5. The individual becomes a resident of a public institutions or prison.[18]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[19]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the

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[7] 20 C.F.R. § 416.202.
[8] 42 U.S.C. § 426.
[9] 42 U.S.C. § 426-1.
[10] 20 C.F.R. § 416.204.
[11] 20 C.F.R. §§ 416.1331-1335.
[12] 20 C.F.R. §§ 416.1320-1330.
[13] 20 C.F.R. § 1320.
[14] 20 C.F.R. § 416.207.
[15] 20 C.F.R. § 416.210.
[16] 20 C.F.R. § 416.214.
[17] 20 C.F.R. § 416.215.
[18] 20 C.F.R. § 416.211.
[19] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).

Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[20] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[21] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[22] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[23] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[24]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[25]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that

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[20] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[21] *Id.*
[22] *Id.*
[23] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[24] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[25] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.*, Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[26] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[27] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[28]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[29] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[30]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[31] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[32] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[33] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes

[26] CMS-1498-R at 5.
[27] *Id.*
[28] *Id.* at 5-6.
[29] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[30] *See, e.g.*, 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[31] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[32] *Id.* at 50280.
[33] *Id.* at 50280-50281.

was used."[34] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[35]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[36] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[37] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[38]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[39]

As a result of the Rulings, new regulation and data match process, CMS either calculated new SSI percentages or recalculated existing SSI percentages for hospitals, including the Provider.[40]

Provider's Request for EJR

The Providers assert that under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, over time, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe

[34] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[35] *Id.* at 50285.
[36] CMS-1498-R at 6-7, 31.
[37] *Id.* at 28, 31.
[38] 75 Fed. Reg. at 24006.
[39] CMS-1498-R2 at 2, 6.
[40] The SSI ratios for FY 2009 and 2010 were published on March 16, 2012 and October 17, 2012, respectively. *See* https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

"entitled to [SSI] benefits" narrowly. In order to be counted in the numerator of the Medicare fraction in the DSH calculation, an SSI enrollee must actually have received a cash payment from SSA for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[41]

The Providers note that in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the preamble to the FY 2011 IPPS Final Rule that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the statutory provisions governing the DSH calculation.[42] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for *or* entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the Medicare statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' DPP calculations to which they are entitled pursuant to § 951 of the Medicare Prescription Drug, Improvement and Modernization Act.[43]

Decision of the Board

A. Applicability of CIRP Regulations and Earlier Board Decision for Ascension Health

The Board reviewed the documents included in the record for Dell Seton Medical Center at the University of Texas, (Provider No. 45-0124, FYE 6/3/2007) ("Dell Seton" or "Provider").[44,45] The letter of representation attached to Dell Seton's original hearing request uses letterhead confirming that Dell Seton is an Ascension facility.[46] As set forth below, Dell Seton improperly failed to join the common issue related party ("CIRP") group under Case No. 13-1618GC as required by 42 C.F.R. § 405.1837(b)(1) and the Board hereby dismisses Case No. 19-1511.

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[41] 75 Fed. Reg. at 50,275-286.
[42] *Id.* at 50,281.
[43] Pub. L. No. 108-173, § 951, 117 Stat. 2066, 2427 (2003).
[44] The revised NPR for this Provider, included under Ex. P-1 of the EJR request indicates that the Provider was formerly known as Brackenridge Hospital.
[45] In the case of: Hall Render Optional and CIRP Dual/Eligible Group Appeals – Medicare Fractionm, 2017 WL 2812948 (Mar, 27, 2017). *See also* the Board's decisions on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/List-of-PRRB-Decisions.
[46] Provider's EJR request Tab P-1. It is the Board's understanding that the Provider did not begin a partnership with the University of Texas until approximately 10 years after the fiscal year at issue (*i.e.*, FY 2007).

By way of background, on March 27, 2017, the Board issued PRRB Dec. No. 2017-D11, the Hall Render Optional and CIRP Dual Eligible Group Appeals (Hall Render Dual Eligible Group). Among the group cases included in that decision was the Ascension CIRP group for 2007 under Case No. 13-1618GC entitled "Ascension Health 2007 DSH Medicare Fraction Dual Eligible CIRP Group." Because Dell Seton was not included in the CIRP group under Case No. 13-1618GC (and as such was not included in Hall Render Dual Eligible group decision which included the mandatory group for Ascension Health) the Provider's appeal of the single issue of dual eligible days in Case No. 19-1517 violates the requirements of 42 U.S.C. § 1395oo(f) and the regulation at 42 C.F.R. § 405.1837(b)(1) and, accordingly, is improper. 42 U.S.C. 1395oo(f) states that "***[a]ny appeal*** [*i.e.*, individual or group] to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) ***must*** be brought by such providers as a group with respect to any matter involving an issue common to such providers." The Secretary implemented this statutory provision at 42 C.F.R. § 405.1837(b)(1) which requires (*i.e.*, mandates) use of a group appeal where:

> (i)Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and *that arises in cost reporting periods that end* ***in the same calendar year***, and for which the amount in controversy is $50,000 or more in the aggregate, ***must*** *bring the appeal as a group appeal*.
>
> (ii) One or more of the providers under common ownership or control may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for purposes of meeting the $50,000 amount in controversy requirement, and, subject to the Board's discretion, may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for other purposes, such as convenience.
>
> (iii) A group appeal involving two or more providers under common ownership or control must consist entirely of providers under common (to all) ownership or control.[47]

Further Board Rule 19.2[48] requires that mandatory (*i.e.*, CIRP) groups must contain ***all*** providers eligible to join a group appeal. This rule states that:

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[47] (Emphasis added.)

[48] The Board's Rules are found on the internet at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.

> Mandatory (CIRP) Groups
>
> Mandatory CIRP group appeals *must contain **all*** Providers eligible to join the group which intend to appeal the disputed common issue. The Board will determine that a group appeal is fully formed upon:
>
> • written notice from the Group Representative that the group is fully formed, or
> • a Board order issued after the Group Representative has the opportunity to present evidence regarding whether any CIRP providers who have not received final determinations could potentially join the group.[49]

Significantly, Hall Render is the Representative in both the CIRP group under Case No. 13-1618GC ***and*** the current case. In its role as the Representative for the Ascension CIRP group under Case No. 13-1618GC, Hall Render had the responsibility to determine if the CIRP group was fully formed and to know which of any Providers in a commonly owned or controlled organization for the calendar year (in this case Ascension for 2007) have been omitted from the mandatory group appeal. Similarly, as the Representative of Dell Seton, Hall Render has the responsibility to confer with its client to determine if Dell Seton was part of a commonly owned or controlled organization and, if so, to determine if other providers in that organization have one or more issues in common with Dell Seton for 2007 thereby necessitating the formation of CIRP groups as relevant.[50]

Prior to participating in the hearing and decision in the Hall Render Dual Eligible Groups decision 2017-D11, Hall Render would have notified the Board that all of the groups participating in hearing, including the CIRP group under Case No. 13-1618GC, were fully formed to enable the Board to make jurisdictional determination with respect to each participant in the group appeals before rendering a decision on the merits. The Board does deem any CIRP appeal to be fully formed if notified of the need to include addition providers in the group and requires the group representative to notify the Board of the inclusion of the full complement of providers. Given the mandatory group requirements of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1837, the Board issues a single decision for a CIRP appeal of a given issue and for a fiscal year. Since, Dell Seton was not included in the mandatory CIRP appeal under Case No.

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[49] (Emphasis added.)

[50] *See, e.g.*, 42 U.S.C. § 1395oo(f) (stating: "***Any appeal*** [i.e., individual or group] to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) ***must*** be brought by such providers as a group with respect to any matter involving an issue common to such providers." (emphasis added)); 42 C.F.R. § 405.1835(a)(4) (specifying that, for any provider that is under common ownership and control, the provider must include a statement in its individual appeal request that "[t]o the best of the provider's knowledge, no other provider to which it is related by common ownership or control, has pending a request for a Board hearing pursuant to this section or pursuant to § 405.1837(b)(1) on any of the same issues contained in the provider's hearing request for a cost reporting period that ends within the same calendar year as the calendar year covered by the provider's hearing request").

13-1618GC, which was one of the cases in PRRB decision 2017-D11, as required by the relevant statute and regulation, the Board hereby dismisses Case No. 19-1511 and denies Dell Seton's request for EJR.

B. Appeals of Revised NPRs and the SSI Realignment

Even if Dell Seton was not a CIRP provider and had a valid appeal of the Dual eligible issue before the Board, the Board would find that it lacked jurisdiction over the Provider's appeal and deny the Provider's request for EJR because the Provider appealed its revised NPR that did not adjust the dual eligible issue as required for Board jurisdiction, rather it was an appeal of an SSI realignment.

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

The regulation, 42 C.F.R. § 412.106(b)(3), permits a provider to request to have its data reported on its cost reporting period instead of the Federal fiscal year. To do so, "It must furnish to CMS, through its Intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period."

Dell Seton requested that its SSI percentage be recalculated from the Federal fiscal year to its respective cost reporting year. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used.[51] The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the September 30 FFY.[52]

The regulation, 42 C.F.R. § 405.1889 (2012), states that:

> (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

[51] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). Similarly, CMS' policy on Part C days was set in the FFY 2005 Final Rule and is incorporated into and reflected in this data matching process. *See* 75 Fed. Reg. at 50276, 50285-6.

[52] As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis.

> revision must be considered a separate and distinct determination or decision to which the provisions of . . . § 405.1835 . . . 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.

Since the revised NPR for Dell Seton did not adjust the dual eligible days issue as required by 42 C.F.R. § 405.1889, the Board would have found that it lacks jurisdiction over the revised NPR and dismissed the appeal. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Provider's request for EJR would have been denied even if Dell Seton had properly joined the CIRP group.

C. Summary

As explained above, the Board denies Dell Seton's request for EJR and dismisses Case No. 19-1511 because Dell Seton failed to transfer the sole issue in this case (the SSI days issue) to the mandatory CIRP group under Case No. 13-1618GC prior to its closure upon the Board's issuance of PRRB Dec. No. 2017-D11. Accordingly, the Board hereby closes Case No. 19-1511. 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.
Charlotte F. Benson, CPA
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For the Board:

12/4/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Justin Lattimore, Novitas Solutions
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination***
20-0296 Hospital for Special Surgery, Provider No. 33-0270, FYE 12/31/17

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's November 6, 2019 request for expedited judicial review ("EJR"). The decision of the Board is set forth below.

The issue for which EJR is requested is:

> . . .the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Provider assert that] the regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the statute because it determines the cap after application of weighting factors.[1]

Background

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

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

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and

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

3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[5]

This appeal concerns the first component of the DGME payment calculation—the resident FTE count.

The Medicare Statute

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

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

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

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

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or

[5] 42 U.S.C. § 1395(h).
[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

> 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

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

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

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

[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

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

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

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

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[13] This regulation is the focus of these appeals and this EJR request, and it states the following:

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

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

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

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

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

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

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

The Provider's Position

The Provider asserts that the MAC's calculations of the current, prior-year and penultimate-year DGME FTES and the FTE caps are contrary to the statutory provisions at 42 U.S.C. § 1395ww(h), and, as a result , the Provider's DGME payments are understated. The Provider contends that the regulation implementing the cap and the weighting factors is contrary to the statute because it determines the cap after the application of the weighting factors.[17] The effect of this regulation is to impose on the Provider a weighting factor that result in reductions greater than 0.5 for many residents who are beyond the IRP, and the regulation prevents the Provider from claiming and receiving reimbursement for their full unweighted FTE caps.[18]

The Provider explains that the Medicare statute caps the number of residents that a hospital can claim at the number it trained in cost years ending in 1996.[19] The statute states that, for residents beyond the IRP, "the weighting factor is .50."[20] The statute also states that the current year FTEs are capped before application of the weighting factors: "the total number of full-time equivalent residents before application of the weighting factors . . . may not exceed the number . . . of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996."[21] The Provider concludes that this statutory scheme sets an absolute weighting factor on fellows of 0.5 and requires that the weighting factors are not applied when capping the current year FTEs.

The Provider claims that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[22] Instead, a weighted FTE cap is determined for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE(UCAP/UFTE) = WCap,[23] is applied to the weighted FTE count in the current year which creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Providers contend that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[24]

Second, the Provider posits, the weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The Provider explains that the downward impact on the FTE count increases as hospital trains more residents beyond the IRP and the problem increase as a hospital trains more fellows because the methodology amplifies the reduction.

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[17] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[18] 42 C.F.R. § 413.79(c)(2).
[19] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[20] *Id.* at § 1395ww(h)(4)(C)(iv).
[21] *Id.* at 1395ww(h)(4)(F)(i).
[22] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[23] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[24] *Id.* at §1395(h)(4)(F)(i).

Third, in some situations, as demonstrated by the Table on page 12 of the Provider's EJR request, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Provider points out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.

The Provider concludes that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion. Since, the Board lacks the authority to grant the relief sought, the request for EJR should be granted.

Decision of the Board

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

A. Compliance with requirements for filing a Board appeal

The Provider in this case is appealing based on the Medicare Contractor's failure to issue a timely final determination under the provisions of 42 C.F.R. § 405.1835(c). This regulation permits a provider to file an appeal with the Board where:

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's *perfected cost* report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .[25]

The Provider's documentation demonstrates that the timely filing requirements of the regulation have been and the participant's documentation shows that the estimated amount in controversy

[25] (emphasis added).

exceeds $10,000, as required for an individual appeal.[26] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying participant. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873

The Provider appealed from the Medicare Contractors failure to time issue a final determination for cost reporting period ending December 31, 2017, and is subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[27] Specifically, effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[28]

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"[29] 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.[30] As no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[31] 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.[32] As a

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[26] *See* 42 C.F.R. § 405.1835.
[27] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[28] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[29] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[30] *See* 42 C.F.R. § 405.1873(a).
[31] 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."
[32] The Provider appealed certain protested amounts included on the cost report based on the Medicare Contractor's failure to issue a final determination within 12 months of the receipt of the Provider's cost report. Since no final determination has been issued, there is no adjustment to protested amounts. However, Exhibit 1 of the EJR request contains Worksheet E Part A, Line 75 which claims $241,023 as the protested which ties to calculation of the

result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board's Analysis of the Appealed Issue

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

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

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[34] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[35] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the Providers that § 413.79(c)(2)(iii) essentially states the above equation, albeit in a slightly

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reimbursement impact and narrative accompanying the claim for the protested amount. This suggests that the Provider complied with the requirements of 42 C.F.R. § 413.24(j).

[33] EJR Request at 4.

[34] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).

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

different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) states:

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

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[37] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[38] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[39] (*i.e.*, ratios) using variables a, b, c, and d:

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

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

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[36] (Emphasis added.)

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

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

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

[40] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted

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

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

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

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

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

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

D. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participant's assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), there are no findings of fact for resolution by the Board;

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

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FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

12/4/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Pam VanArsdale, NGS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Mail

Sven Collins
Squire Patton Boggs (US) LLP
1801 California St., Ste. 4900
Denver, CO 80202

RE: ***Jurisdictional Decision***
Lee Memorial CY 2016 DSH Uncompensated Care CIRP Group
FYE 12/31/2016
Case No. 18-1818GC

Dear Mr. Collins,

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

Pertinent Facts:

The above referenced CIRP group appeal was formed on August 22, 2018. The group was fully formed on August 22, 2019 and currently contains three providers, all of which are appealing based on the Medicare Contractor's ("MAC") failure to issue a timely determination.[1]

The issue being appealed is whether the MAC improperly accounted for certain types of patient days related to the uncompensated care calculation in calculating the DSH adjustment. The Providers allege that the current Medicare cost report instructions related to Worksheet S-10 are ambiguous and, if clarified, the uncompensated care costs may change. They also claim that "potentially" there are errors in the published uncompensated care amounts, but that CMS has not provided enough detail to be able to identify the errors. Providers are filing their appeal to preserve future appeal rights in the event that future uncompensated care costs are determined based on the data being reported now, which they believe is flawed. Finally, the Providers state that they do not intend to simply challenge audit adjustments, but the Secretary's underlying policy related to the uncompensated care calculation, insofar as it uses the Worksheet S-10 data, which is allegedly reported based on ambiguous instructions.[2]

[1] The Lead MAC filed its 30 Day Response on October 24, 2018. In that response, the MAC claims that two providers in the group submitted amended cost reports, and that the issuance of an NPR from those amended reports was not yet untimely. As a result, they argue that the appeal for these providers is premature and should be dismissed. The Providers responded on October 26, 2018. They claim that this same argument was rejected by the Administrator in a district court case, wherein the parties agreed to remand the case to the Board with instructions to assert jurisdiction. They argue that the Board has historically asserted jurisdiction over the failure to timely issue an NPR, even if an amended cost report was submitted and pending. The Board is not opining on the assertions, as they will not be dispositive of the case.

[2] Group Appeal Request, Tab 2.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
>
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[3] and
>
> (B) Any period selected by the Secretary for such purposes.[4]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[5] the D.C. Circuit Court upheld a D.C. District Court decision[6] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit affirmed the District Court's finding that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[7] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying

[3] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.
[4] (Bold emphasis added and italics emphasis in original.)
[5] 830 F.3d 515 (D.C. Cir. 2016).
[6] 89 F. Supp. 3d 121 (D.D.C. 2015).
[7] 830 F.3d 515, 517.

data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[8] The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[9] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[10]

In 2019, the D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[11] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding in *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.

The Board finds that the same findings are applicable to the Provider's challenge to their UCC payments in this appeal. The Providers are challenging the Secretary's methodology for collecting the underlying data for UCC DSH payments, claiming that certain instructions are ambiguous. This deficient methodology may have resulted in unspecified errors in the actual data itself, which they also challenge in their appeal. The statute and regulation found at 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) specifically bar administrative and judicial review of the estimates used by the Secretary in calculating the UCC payments. Furthermore, a challenge to any underlying data (or lack of support for the data used) is barred, as well. *Tampa General* specifically held that the underlying data used for UCC payments cannot be reviewed or challenged. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Providers could bring suit in the D.C. Circuit.[12]

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[8] *Id.* at 519.
[9] *Id.* at 521-22.
[10] *Id.* at 522.
[11] 925 F.3d 503 (D.C. Cir. 2019).
[12] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n,* Adm'r Dec. (Apr. 13, 2009),

Based on the above analysis, the Board concludes that it does not have jurisdiction over the UCC DSH issue in this appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the UCC DSH issue is the only issue in the appeal, the Board hereby closes the referenced appeal and removes it from its docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

12/9/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc. (J-N)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Mail

Stephanie Webster
Akin Gump Strauss Hauer & Feld, LLP
2001 K Street, N.W.
Washington, D.C. 20006

RE: ***Jurisdictional Decision***
Montefiore Health CY 2015 DSH Uncompensated Care Factor III CIRP Group
FYE 2015
Case No. 19-2184GC

Dear Ms. Webster,

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

Pertinent Facts:

The above referenced CIRP group appeal was formed on March 8, 2019, and currently contains four providers, which are appealing Notices of Program Reimbursement.

The issue being appealed is a challenge to the DSH payment based on the underlying calculation of the Providers' UCC. Specifically, the Providers dispute CMS's calculation of Factor 3 as inconsistent with the plain language and intent of the statute governing the new DSH methodology, arbitrary and capricious, not based upon substantial evidence, and otherwise contrary to law. They also argue that it unlawfully fails to reflect the best available data.[1] The Providers elaborate, claiming that Factor 3 excludes certain patient days that were not yet known or documented to be eligible for Medicaid at the time the applicable cost reports were due, and generally that the figures used were not based on the best available data. They specifically challenge 42 C.F.R. § 412.106(g)(1)(iv), which fixes the timing of the final determination of the DSH UCC payment amount as of the time when the final IPPS rule was promulgated instead of using later, more accurate data.[2]

The Providers acknowledge the bar on administrative and judicial review of estimates used by the Secretary pursuant to 42 U.S.C. § 1395rr(w)(3), but argue that the choice of data or the actual determination of the DSH UCC payment amounts is not within that preclusion. They also claim the right to challenge the regulation fixing the time period for calculating the DSH UCC payment amounts is not precluded by statute or regulation.[3]

[1] Group Issue Statement at 1.
[2] *Id.* at 2.
[3] *Id.*

The Lead Medicare Contractor ("MAC") filed its 30 Day Response on July 30, 2019. In that response, the MAC noted that it believes that a jurisdictional impediment exists, namely that the DSH payment for Uncompensated Care has been explicitly barred from administrative and judicial review per 42 U.SC. § 1395ww(r)(3). The MAC further noted that it would be filing a jurisdictional challenge at a later date, but the Board has not received such a challenge to date.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
>
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[4] and
>
> (B) Any period selected by the Secretary for such purposes.[5]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[6] the D.C. Circuit Court upheld a D.C. District Court decision[7] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit affirmed the District Court's finding that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold

[4] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.

[5] (Bold emphasis added and italics emphasis in original.)

[6] 830 F.3d 515 (D.C. Cir. 2016).

[7] 89 F. Supp. 3d 121 (D.D.C. 2015).

that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[8] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[9] The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[10] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[11]

In 2019, the D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[12] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.

The Board finds that the same findings are applicable to the Providers' challenge to their UCC payments in this appeal. The Providers are specifically appealing the Secretary's choice of data for uncompensated care costs – namely several categories of patient day counts, claiming that more accurate data was available to use. The statute and regulation found at 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) specifically bar administrative and judicial review of the estimates used by the Secretary in calculating the UCC payments. Furthermore, a challenge to any underlying data (or lack of support for the data used) is barred, as well. *Tampa General* specifically held that the underlying data used for UCC payments cannot be reviewed or challenged. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's

[8] 830 F.3d 515, 517.
[9] *Id.* at 519.
[10] *Id.* at 521-22.
[11] *Id.* at 522.
[12] 925 F.3d 503 (D.C. Cir. 2019).

decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Providers could bring suit in the D.C. Circuit.[13]

Based on the above analysis, the Board concludes that it does not have jurisdiction over the UCC DSH issue in this appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the UCC DSH issue is the only issue in the appeal, the Board hereby closes the referenced appeal and removes it from its docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

12/9/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Pam VanArsdale, National Government Services, Inc. (J-K)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Mail

Gary Zeman
Strategic Reimbursement Group, LLC
360 W. Butterfield Road
Suite 310
Elmhurst, IL 60126

RE: ***Jurisdictional Decision***
Advocate Aurora Health CY 2014 Calculation of Uncompensated Care CIRP Group
FYE 2014
Case No. 19-2215GC

Dear Mr. Zeman,

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

Pertinent Facts:

The above referenced CIRP group appeal was formed on July 11, 2019, but currently only contains one provider, which is appealing a Notice of Program Reimbursement dated May 30, 2018.[1]

The issue being appealed is a challenge to the Disproportionate Share Hospital ("DSH") payment based on the underlying calculation of its Uncompensated Care Costs ("UCC"). Specifically, Provider is appealing CMS' decision to use certain data as a proxy for uncompensated care costs. They argue that doing so is contrary to the statutory directive to calculate a hospital's "amount of uncompensated care." Second, they believe that certain data being used by CMS – data from hospitals' Worksheet S-10's – is flawed and inappropriate to be used as a proxy for calculating uncompensated care costs.[2]

The Lead Medicare Contractor ("MAC") filed its 30 Day Response on August 9, 2019. In that response, the MAC noted that it believes that a jurisdictional impediment exists, namely that the DSH payment for Uncompensated Care has been explicitly barred from administrative and judicial review per 42 U.SC. § 1395ww(r)(3). The MAC further noted that it would be filing a jurisdictional challenge at a later date, but the Board has not received such a challenge to date.

[1] The Provider was transferred from an individual appeal that is now closed: Case No. 19-0600.
[2] Group Issue Statement.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
>
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[3] and
>
> (B) Any period selected by the Secretary for such purposes.[4]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[5] the D.C. Circuit Court upheld a D.C. District Court decision[6] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

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

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[3] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.

[4] (Bold emphasis added and italics emphasis in original.)

[5] 830 F.3d 515 (D.C. Cir. 2016).

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

[7] 830 F.3d 515, 517.

[8] *Id.* at 519.

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[9] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[10]

In 2019, the D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[11] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.

The Board finds that the same findings are applicable to the Providers' challenge to their UCC payments in this appeal. The Provider is specifically appealing the Secretary's choice of data and their use as proxies for uncompensated care costs – namely the Medicare SSI and Medicaid patient counts from prior cost reporting years, and more recently, certain Worksheet S-10 data. The statute and regulation found at 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) specifically bar administrative and judicial review of the estimates used by the Secretary in calculating the UCC payments. Furthermore, a challenge to any underlying data (or lack of support for the data used) is barred, as well. *Tampa General* specifically held that the underlying data used for UCC payments cannot be reviewed or challenged. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Provider could bring suit in the D.C. Circuit.[12]

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[9] *Id.* at 521-22.
[10] *Id.* at 522.
[11] 925 F.3d 503 (D.C. Cir. 2019).
[12] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or

Based on the above analysis, the Board concludes that it does not have jurisdiction over the UCC DSH issue in this appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the UCC DSH issue is the only issue in the appeal, the Board hereby closes the referenced appeal and removes it from its docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

12/9/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Danene Hartley, National Government Services, Inc. (J-6)

the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Mail

Randall Gienko
Strategic Reimbursement Group, LLC
360 W. Butterfield Rd., Ste. 310
Elmhurst, IL 60126

RE: ***Jurisdictional Decision***
Strategic Reimbursement Group CY 2016 Uncompensated Care Group
FYE 2016
Case No. 19-2407G

Dear Mr. Gienko,

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

Pertinent Facts:

The above referenced group appeal was formed on August 13, 2019, and currently contains two providers, which are appealing Notices of Program Reimbursement.

The issue being appealed is a challenge to the Disproportionate Share Hospital ("DSH") payment based on the underlying calculation of its Uncompensated Care Costs ("UCC"). Specifically, Providers are appealing CMS' decision to use certain data as a proxy for uncompensated care costs. They argue that doing so is contrary to the statutory directive to calculate a hospital's "amount of uncompensated care." Second, they believe that certain data being used by CMS – data from hospitals' Worksheet S-10's – is flawed and inappropriate to be used as a proxy for calculating uncompensated care costs.[1]

The Lead Medicare Contractor ("MAC") filed its 30 Day Response on August 30, 2019, but did not note any jurisdictional impediments at that time.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

[1] Group Issue Statement.

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
>
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[2] and
>
> (B) Any period selected by the Secretary for such purposes.[3]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[4] the D.C. Circuit Court upheld a D.C. District Court decision[5] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit affirmed the District Court's finding that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[6] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[7] The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[8] Finally, it addressed the argument that the

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[2] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.

[3] (Bold emphasis added and italics emphasis in original.)

[4] 830 F.3d 515 (D.C. Cir. 2016).

[5] 89 F. Supp. 3d 121 (D.D.C. 2015).

[6] 830 F.3d 515, 517.

[7] *Id.* at 519.

[8] *Id.* at 521-22.

estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[9]

In 2019, the D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[10] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.

The Board finds that the same findings are applicable to the Providers' challenge to their UCC payments in this appeal. The Providers are specifically appealing the Secretary's choice of data and their use as proxies for uncompensated care costs – namely the Medicare SSI and Medicaid patient counts from prior cost reporting years, and more recently, certain Worksheet S-10 data. The statute and regulation found at 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) specifically bar administrative and judicial review of the estimates used by the Secretary in calculating the UCC payments. Furthermore, a challenge to any underlying data (or lack of support for the data used) is barred, as well. *Tampa General* specifically held that the underlying data used for UCC payments cannot be reviewed or challenged. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Providers could bring suit in the D.C. Circuit.[11]

Based on the above analysis, the Board concludes that it does not have jurisdiction over the UCC DSH issue in this appeal because judicial and administrative review of the calculation is barred by statute and

[9] *Id.* at 522.
[10] 925 F.3d 503 (D.C. Cir. 2019).
[11] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

regulation. As the UCC DSH issue is the only issue in the appeal, the Board hereby closes the referenced appeal and removes it from its docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

12/9/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Danene Hartley, National Government Services, Inc. (J-6)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21207
410-786-2671

Via Electronic Mail

Sven Collins
Squire Patton Boggs (US) LLP
1801 California St., Ste. 4900
Denver, CO 80202

RE: ***Jurisdictional Decision***
Lee Memorial FFY 2017 Squire Patton Boggs 2017 DSH Uncompensated Care CIRP Group
FYE CY 2017
Case No. 19-2544GC

Dear Mr. Collins,

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

Pertinent Facts:

The above-referenced CIRP group appeal was formed on August 27, 2019. The group currently contains three providers, all of which are appealing based on the Medicare Contractor's ("MAC") failure to issue a timely determination.

The issue being appealed is whether the MAC improperly accounted for certain types of patient days related to the uncompensated care calculation in calculating the DSH adjustment. The Providers allege that the current Medicare cost report instructions related to Worksheet S-10 are ambiguous and, if clarified, the uncompensated care costs may change. They also claim that "potentially" there are errors in the published uncompensated care amounts, but that CMS has not provided enough detail to be able to identify the errors. Providers are filing their appeal to preserve future appeal rights in the event that future uncompensated care costs are determined based on the data being reported now, which they believe is flawed. Finally, the Providers state that they do not intend to simply challenge audit adjustments, but the Secretary's underlying policy related to the uncompensated care calculation, insofar as it uses the Worksheet S-10 data, which is allegedly reported based on ambiguous instructions.[1]

The Lead MAC filed its 30 Day Response on September 17, 2019. In that response, the MAC states that the amount in controversy cannot be established since the final determinations have not been issued for each provider.

[1] Group Appeal Request, Tab 2.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
>
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[2] and
>
> (B) Any period selected by the Secretary for such purposes.[3]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[4] the D.C. Circuit Court upheld a D.C. District Court decision[5] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

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[4] 830 F.3d 515 (D.C. Cir. 2016).

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[7] *Id.* at 519.

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[8] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[9]

In 2019, the D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[10] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding in *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.

The Board finds that the same findings are applicable to the Providers' challenge to their UCC payments in this appeal. The Providers are challenging the Secretary's methodology for collecting the underlying data for UCC DSH payments, claiming that certain instructions are ambiguous. This deficient methodology may have resulted in unspecified errors in the actual data itself, which they also challenge in their appeal. The statute and regulation found at 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) specifically bar administrative and judicial review of the estimates used by the Secretary in calculating the UCC payments. Furthermore, a challenge to any underlying data (or lack of support for the data used) is barred, as well. *Tampa General* specifically held that the underlying data used for UCC payments cannot be reviewed or challenged. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Providers could bring suit in the D.C. Circuit.[11]

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[8] *Id.* at 521-22.
[9] *Id.* at 522.
[10] 925 F.3d 503 (D.C. Cir. 2019).
[11] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or

Based on the above analysis, the Board concludes that it does not have jurisdiction over the UCC DSH issue in this appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the UCC DSH issue is the only issue in the appeal, the Board hereby closes the referenced appeal and removes it from its docket.

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

Board Members Participating:

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For the Board:

12/9/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc:

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the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Jurisdictional Decision***

19-2586GC	Baptist Healthcare KY CY 2016 Uncompensated Care Payments Using Improper S-10 Audits CIRP
19-2630G	Hall Render CY 2016 Uncompensated Care Payments Using Improper 2015 S-10 Audits Group
20-0045GC	Cook County Health CY 2015 Uncompensated Care Payments Using Improper S-10 Audits CIRP

Dear Ms. O'Brien Griffin,

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

Pertinent Facts:

The Providers are appealing original or revised Notices of Program Reimbursement ("NPRs" or "RNPRs") for various fiscal years ending in calendar year ("CY") 2016. The issue being appealed is a challenge to the Disproportionate Share Hospital ("DSH") payment for Uncompensated Care Costs ("UCC"). Specifically, Providers are appealing the Medicare Contractors' ("MACs'") alleged failure to include appropriate costs on their S-10 worksheets for FFY 2015, which impacts their FY 2020 UCC DSH payments. They claim that their S-10's were arbitrarily audited without issuing adequate UCC reporting guidelines or going thorough adequate notice and comment requirements. They state that audits of hospitals' S-10's was inconsistent and unfair. The Providers raise several arguments about the accuracy of the S-10 data used, and the methodology in auditing those worksheets. While they acknowledge that the estimates used by the Secretary for the UCC DSH payment is not subject to review, they claim "whether the underlying data [CMS] use[s] for making their estimates is 'adequate' IS subject to review." Providers claim the disparate treatment the MAC's showed in auditing different hospitals' S-10 worksheets is unlawful and *ultra vires*, and that a statutory bar on administrative and judicial review does not extend to these types of actions. Finally, the Providers state that the D.C. Circuit's 2014 decision in *Allina Health Servs. v. Sebelius* ("*Allina*")[1] holds that "when CMS does anything affecting benefits, payment, or eligibility, it must first through [*sic*] the notice-and-comment requirement under the Medicare statute."[2]

The Medicare Contractor filed a thirty day letter in one of the above referenced cases.[3] In its letter, the MAC argues that the appeal is not suitable for a group appeal because there are multiple issues, and the

[1] 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[2] Group Issue Statement.
[3] MAAC Response Required Under Rule 15 (Oct. 8, 2019) (Case No. 19-2630G).

fact that certain contested sampling techniques and extrapolations would not necessarily be a common issue between the Providers.

The Providers filed a reply to the letter, but did not address the MAC's contentions.[4] Instead, the reply focuses on whether the appealed issue is precluded from administrative review pursuant to 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). They argue that CMS' failure to undertake appropriate notice and comment procedures related to the S-10 audit methodology renders the resulting data inadequate, and that the bar on review does not extend to matters that violate the Medicare Statute's notice and comment requirements. They clarify that the appeals "center[] on two key agency errors: (1) CMS's failure to fulfill its requirements under the APA and Medicare Statute's notice and comment requirements; and (2) appealing a patently unlawful agency action." For support they cite a recent case at the U.S. District Court for Connecticut, stating the following:

> The Connecticut District court recently reviewed an [Uncompensated Care] payment issue in *Yale New Haven Hospital v. Azar*[,Case No. 3:18-CV-1230, 2019 WL 3387041 (D. CN., July 25, 2019)] and applied the Supreme Court's recent ruling in *Allina*. (Exhibit P-6). In Yale New Haven, the only surviving claim stemmed from the question of:
>
> > whether the preclusion provision [of 42 U.S.C. § 1395ww(r)(3)] encompasses procedural aspects involved in the adoption of the rule that governed the determination by the Secretary of the "estimates."
>
> Despite the judicial bar in the UC DSH statute, the Court pulled from the *Allina* decision in agreeing that the Hospital's claims challenging "the procedure by which the Secretary established" a FFY 2014 policy is "separate from the substance of any such rules or policies or the determination of its estimates based on the substance of those rules or policies" and is thus not barred by judicial review.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

> *Preclusion of administrative and judicial review.* There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:

[4] Provider's Response to the Medicare Administrative Contractor's Rule 15.2 Letter (Nov. 8, 2019) (Case No. 19-2630G).

> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[5] and
>
> (B) Any period selected by the Secretary for such purposes.[6]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[7] the D.C. Circuit Court upheld a D.C. District Court decision[8] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit affirmed the District Court's finding that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[9] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[10]

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[11] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[12]

In 2019, the D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[13] In *DCH v. Azar*, the

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[5] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.
[6] (Bold emphasis added and italics emphasis in original.)
[7] 830 F.3d 515 (D.C. Cir. 2016).
[8] 89 F. Supp. 3d 121 (D.D.C. 2015).
[9] 830 F.3d 515, 517.
[10] *Id.* at 519.
[11] *Id.* at 521-22.
[12] *Id.* at 522.
[13] 925 F.3d 503 (D.C. Cir. 2019).

provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[14] It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D.C. Circuit then applied this holding *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.[15]

The Board recognizes that the Connecticut District Court recently considered the bar on review of UCC DSH payments in *Yale New Haven Hospital v. Azar* ("*Yale New Haven*").[16] There, the Court dismissed all of the providers' counts in their federal complaint except one. Those that clearly sought to "undo the Secretary's estimate of its uncompensated care by recasting its challenge to that estimate as an attack on the underlying methodology" were dismissed.[17] The Court held that the remaining count did "not challenge the Secretary's estimate of [the provider's] DSH payment, any of the underlying data, or the Secretary's choice of such data. Instead, it [was] a challenge to the procedure by which the Secretary established the" issue under appeal. The Court found that it was a close call, but that there was no bar on review of "the *promulgation* of the Secretary's rules and policies, separate from the *substance* of any such rules or policies or the determination of its estimates based on the substance of those rules or policies."[18]

Notwithstanding *Yale New Haven*, the Board finds that the same findings in *Tampa General* and *DCH v. Azar* are applicable to the Providers' challenge to their UCC payments in this appeal. The Providers are appealing from NPRs and RNPRs related to fiscal years ending in 2016, appealing the amount of DSH UCC payments they will receive for FY 2020, which may be based on data from the fiscal years under appeal. The Providers claim to be challenging arbitrary and capricious or *ultra vires* actions of CMS in their failure to provide notice and receive comments on how the data for FY 2020 would be collected. It is ultimately a direct attack against the underlying methodology used to generate the Secretary's estimates for DSH UCC purposes, which is not reviewable.[19] The statute and regulation found at 42

[14] *Id.* at 506.
[15] *Id.* at 507.
[16] 2019 WL 3387041 (July 25, 2019).
[17] *Id.* at *8 (quoting *DCH v. Azar* at 508).
[18] *Id.* at *9.
[19] *DCH v. Azar* at 507. It is true that the district court case cited by the Providers (*Yale New Haven*) has a narrow holding and permitted a direct attack against a policy that failed to follow notice and comment procedures because it was not a challenge to the Secretary's estimate of that hospital's payment or any specific underlying data. Here, the Providers have listed an amount in controversy related to their specific hospitals, which they believe should be higher based on different S-10 worksheet data. They are "simply trying to undo the Secretary's estimate of [their] uncompensated care by recasting [their] challenge to that estimate as an attack on the underlying methodology." *DCH v. Azar* at 508. Finally, the Board notes that, as confirmed in *infra* note 20 and the accompanying text, *Yale New Haven* is not binding precedent on the Board unlike *Tampa General* and *DCH v. Azar*.

U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) specifically bar administrative and judicial review of the estimates used by the Secretary in calculating the UCC payments. Furthermore, a challenge to any underlying data (or lack of support for the data used) is barred, as well. *Tampa General* specifically held that the underlying data used for UCC payments cannot be reviewed or challenged. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Providers could bring suit in the D.C. Circuit.[20]

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

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

Board Members Participating:

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For the Board:

12/9/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Geoff Pike, First Coast Service Options
Judith Cummings, CGS Administrators
Danene Hartley, National Government Services, Inc.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Stephen Price, Sr., Esq.
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Louisville, KY 40202

RE: ***Expedited Judicial Review Determination***
Appalachian Regional Healthcare 2007 DSH SSI Ratio Part C Days Group
Case No. 13-1903GC

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' September 18, 2019 request for expedited judicial review ("EJR") (received September 19, 2019) and the Providers' November 12, 2019 resubmission of the Schedules of Providers and jurisdictional documents (received November 13, 2019) for the appeal referenced above.[1] The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in this appeal is:

> [Whether] [t]he [Medicare Contractor's] calculation of the Providers' disproportionate patient percentage, used for the purposes of calculating the Medicare Disproportionate Share (DSH) Adjustment, was incorrect due to the [Medicare Contractor's] Adjustment improperly excluding Medicare Advantage (Part C) days from the numerator of the Medicaid fraction and improperly including Medicare Advantage (Part C) days in the Medicare fraction used to calculate the DSH payment.[2]

[1] The Board issued a development letter dated October 17, 2019 for additional information. This request for additional information affected the 30-day period for responding to the EJR request. See 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii).
[2] Provider's EJR request at 1-2.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[10]

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

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[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] (Emphasis added.)
[11] 42 C.F.R. § 412.106(b)(2)-(3).

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[13]

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[14] stated that:

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

[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.

> allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [18]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[19]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to

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[15] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[16] *Id.*
[17] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[18] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[20] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[21]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.[22] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[23] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[24]

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[20] 69 Fed. Reg. at 49099.
[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] 72 Fed. Reg. at 47411.
[24] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[25] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[26] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[28] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[29] Once again, the Secretary has not acquiesced to this decision. The Supreme Court issued a decision in *Azar v. Allina Health Services* ("*Allina III*")[30] in which the Court considered whether the government had violated the 60-day notice requirement of 42 U.S.C. § 1395hh(a)(2) when it posted the 2012 Medicare fractions on its website. Affirming the court of appeals finding, the Court concluded that §1395hh(a)(2) the government's action changed a substantive legal standard and, thus required notice and comment.

Providers' Request for EJR

In light of the Supreme Court's decision in Allina, the Providers contend that the pre-2004 standard of excluding Part C days from the Medicare fraction should be the baseline practice from which the decision by the Medicare Contractor to include Part C days in the Medicare fraction is evaluated. 42 U.S.C. § 1395hh(a)(4) should apply here with full force and the Secretary should not be able to circumvent this requirement by claiming he was acting by way of adjudication rather than rulemaking. The statutory text says that the vacated rule may not 'take effect' at all until there has been notice and comment. The Providers assert that Part C days should be excluded from the Medicare fraction and included in the Medicaid fraction of the DSH adjustment.

The Providers are also seeking interest if it is the prevailing party in any judicial review under 42 U.S.C. § 1395oo(f)(2). They recognize that the Court in *Shands Jacksonville Medical Center v. Azar*[31] found that providers that did not have a case pending on the date the rule was finalized could not be awarded interest. The Providers, who have been advised by the Medicare Contractor that they have received no instructions from the Secretary with respect to resolving

[25] 746 F. 3d 1102 (D.C. Cir. 2014).
[26] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[27] 863 F.3d 937 (D.C. Cir. 2017).
[28] *Id.* at 943.
[29] *Id.* at 943-945.
[30] No. 17-1484, 2019 WL 2331304 (June 3, 2019).
[31] 2019 WL 1228061 (D.D.C. 2019).

the Part C issue have advised the Providers that they need to continue with the cases. Consequently, the Providers have requested EJR to resolve the interest issue. If the Secretary should acquiesce to the decision in the *Allina* cases before EJR is granted and suit can be filed, then the Providers request that interest be awarded under the provisions of 42 U.S.C. § 1395g(d).[32]

Decision of the Board

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

Jurisdiction

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

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[33] 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.[34]

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[32] 42 U.S.C. § 1395g(d) states that:

> Whenever a final determination is made that the amount of payment made under this part to a provider of services was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.

[33] 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.).

[34] *Bethesda*, 108 S. Ct. at 1258-59.

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 Notice of Program Reimbursement (NPR).[35] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda*. The Providers which filed appeals of revised NPRs have an adjustment to Part C Days as required. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[36] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

With respect to the Providers' request for interest if the EJR was denied,[37] the Board notes that it does not need to consider the request at this time as the Secretary has not acquiesced to the Supreme Court's decision in *Allina I, II* or *III*. However, if the Board were to consider the interest issue, it would be required to address: (1) whether the Providers timely raised the interest issue as part of the original appeals or timely added it to the appeals in compliance with the requirements of 42 C.F.R. § 405.1835 and (2) whether the type of interest being requested by the Providers falls outside the cost report and, hence, the jurisdiction of the Board.

Board's Analysis Regarding the Appealed Issues

The appeals in this EJR request involve the 2007 cost reporting period. Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[38] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[39] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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[35] See 42 C.F.R. § 405.1889(b)(1) (2008).
[36] *See* 42 C.F.R. § 405.1837.
[37] *See* 42 U.S.C. § 1395oo(f)(1).
[38] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[39] *See* 42 U.S.C. § 1395oo(f)(1).

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the case.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

12/10/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

Enclosures: Schedule of Providers
cc: Judith Cummings, CGS Administrators, Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: **EJR Determination Hall Render DSH Dual Eligible SSI Patient Days Groups**

15-0667GC	Care New England Health System 2010 DSH Medicare Fraction Dual Eligible
15-0922GC	Care New England Health System 2011 Medicare Fraction Dual Eligible Days
15-1863GC	Beacon Health 2010 DSH Medicare Fraction Dual Eligible Days CIRP
15-3023GC	Care New England 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
16-1596GC	Truman Medical Centers, Inc. 2013 DSH Dual Eligible Days CIRP Group
16-1886GC	Advocate Health 2011 DSH Medicare Fraction Dual Eligible Days CIRP Group
16-2313GC	Truman 2010 SSI Fraction Dual Eligible Days CIRP

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' November 11, 2019 request for expedited judicial review ("EJR") (received November 12, 2019) in the above-referenced appeals. The Board's decision with respect EJR is set forth below.

Issue in Dispute

The issue for which the Board is considering EJR is:

> [W]hether the Providers' Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[1]

[1] Providers' EJR Request at 2. The appeal requests for both 15-0067GC and 15-3023GC included the challenge to the DSH fraction, but also and/or low income patient (LIP) fraction for Inpatient Rehabilitation Facilities (IRF's) and or IRF units, as applicable pursuant to 42 U.S.C. 1395ww(d)(5)(F).

Medicare Disproportionate Share Hospital (DSH) Payment Background

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

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[4]

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

[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[4] (Bold emphasis added and italics emphasis in original.)

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[5] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[6] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[7]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[8] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[9]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[10] and may terminate,[11] suspend[12] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[13] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[14]
2. The individual fails to apply for other benefits to which the individual may be entitled;[15]
3. The individual fails to participate in drug or alcohol addiction treatment;[16]
4. The individuals is absent from the United States for more than 30 days;[17] or
5. The individual becomes a resident of a public institutions or prison.[18]

[5] 42 U.S.C. § 1382.
[6] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[7] 20 C.F.R. § 416.202.
[8] 42 U.S.C. § 426.
[9] 42 U.S.C. § 426-1.
[10] 20 C.F.R. § 416.204.
[11] 20 C.F.R. §§ 416.1331-1335.
[12] 20 C.F.R. §§ 416.1320-1330.
[13] 20 C.F.R. § 1320.
[14] 20 C.F.R. § 416.207.
[15] 20 C.F.R. § 416.210.
[16] 20 C.F.R. § 416.214.
[17] 20 C.F.R. § 416.215.
[18] 20 C.F.R. § 416.211.

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[19]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[20] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[21] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[22] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[23] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[24]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[25]

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[19] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[20] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[21] *Id.*
[22] *Id.*
[23] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[24] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[25] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[26] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[27] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[28]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[29] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[30]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[31] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[32] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02

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each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.*, Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[26] CMS-1498-R at 5.

[27] *Id.*

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

[29] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

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

[31] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

[32] *Id.* at 50280.

"accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[33] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[34] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[35]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[36] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[37] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[38]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[39]

As a result of the Rulings, new regulation and data match process, CMS either calculated new SSI percentages or recalculated existing SSI percentages for each of the Providers for all of fiscal years at issue in these appeals.[40] All of the Providers in the groups covered by this EJR decision have appealed from *original* NPRs that used SSI percentages calculated based on the methodology articulated in the preamble to the FY 2011 IPPS Final Rule which includes using only the three SSI codes to denote SSI entitlement under 42 C.F.R. § 412.106(b)(2).

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[33] *Id.* at 50280-50281.
[34] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[35] *Id.* at 50285.
[36] CMS-1498-R at 6-7, 31.
[37] *Id.* at 28, 31.
[38] 75 Fed. Reg. at 24006.
[39] CMS-1498-R2 at 2, 6.
[40] The SSI ratios for FY 2009 and 2010 were published on March 16, 2012 and October 17, 2012, respectively. *See* https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

Providers' Request for EJR

The Providers assert that under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration (SSA) for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[41]

The Providers note that in administering the SSI program, SSA assigns each beneficiary a Patient Status Code (PSC). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[42] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the Medicare statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' DPP calculations which they are entitled to under Section 951 of the Medicare Prescription Drug, Improvement and Modernization Act, P.L. 108-173.

Decision of the Board

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

[41] 75 Fed. Reg. at 50,275-286.
[42] *Id.* at 50,281.

A. Dismissal of LIP Issue from Case Nos. 15-0922GC and 15-3023GC as there are no IRF/LIP providers in these cases.

The statement of the issue that accompanied the original hearing request in Case Nos. 15-0922GC and 15-3023G raised a question concerning both DSH as it relates to IPPS providers ("IPPS/DSH providers") and LIP as it relates to IRF providers ("IRF/LIP providers") of:

> Whether the Medicare Disproportionate Share Hospital (DSH) calculation was understated due to the failure of the Centers for Medicare & Medicaid Services (CMS) and the Fiscal Intermediary (FI) to properly include all Dual Eligible Days that are Medicare Non-Covered Days ("DE MNC Days"), which include but are not limited to Medicare Exhausted Days and MSP (Medicare Secondary Payor) Days were Medicare is secondary to another payor, in the numerator of the Medicare or Medicare fraction of the DSH percentage and/***or low income patient (LIP) fraction for Inpatient Rehabilitation Facilities (IRFs) and or IRF units*** as applicable pursuant to 42 U.S.C. § 1395ww(d)(5)(F).[43]

Case No. 15-0922GC covered fiscal year 2011 and the original Schedule of Providers filed with this case listed five (5) providers – three (3) IPPS/DSH providers and the IRF/LIP provider associated with two (2) of the IPPS/DSH providers.[44] Case No. 15-3023GC covered fiscal year 2012 and the original Schedule of Providers only included one IPPS/DSH provider. Two more IPPS/DSH providers were directly added to Case No. 15-3023GC.

In the other cases containing this same statement of the issue, the LIP issue was transferred to a group appeal. A review of the Board's computer docketing system for Case Nos. 15-0922GC and 15-3023GC could find no evidence of the Group Representative transferring the Dual Eligible Days issue related to the Inpatient Rehabilitation Facilities ("IRFs") to a LIP group appeal. Further, the final Schedule of Providers for Case Nos. 15-0922GC and 15-3023GC did not list any IRF/LIP providers and only included the same three (3) IPPS/DSH providers. Therefore, the Board must conclude that there are no IRF/LIP providers and that the LIP issue is consequently moot. As such, the Board dismisses the LIP issue.

[43] (Emphasis added.)

[44] Specifically, the IPPS/DSH providers on the original Schedule of Providers were: (1) Kent County Memorial Hospital (Provider No. 41-0009) ("Kent County"); (2) Memorial Hospital of Rhode Island (Provider No. 41-0001) ("Memorial"); and (3) Women & Infants Hospital of Rhode Island (Provider No. 14-0010). The IRF/LIP providers were for Kent County under Provider No. 41-T009 and for Memorial under Provider No. 41-T001.

B. In the alternative, had there been IRF/LIP providers in Case Nos. 15-0922GC and 15-3023GC, the Board would dismiss them.

1. Review of Dual Eligible Days in the LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals for the District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* ("*Mercy*")[45] clarifies what is precluded from review in its analysis of this issue.

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[46] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court's decision[47] which concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The D.C. Circuit concluded that the statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[48]

2. Dismissal of the LIP Issue and any associated IRF/LIP providers from Case Nos. 15-0922GC and 15-3023GC

As explained below, if there were IRF/LIP providers Case Nos. 15-0922GC and 15-3023GC, the Board would dismiss the Dual Eligible days issue for LIP (including any LIP/IRF providers associated with that issue) from Case Nos. 15-0922GC and 15-3023GC. Since jurisdiction over an issue is a prerequisite to grant a request for EJR, the Board would denyt the EJR request as it relates to any LIP/IRF providers included in the request for EJR for the LIP issue under Case Nos. 15-0922GC and 15-3023GC.

As previously noted, the Provider did not separately identify the IRF/LIP providers and IPPS/DSH providers on the final Schedule of Providers for Case Nos. 15-0922GC and 15-3023GC.[49] Under the LIP issue, the Providers seek Board review of one of the components

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[45] 891 F.3d 1062 (June 8, 2018).
[46] *Id.* at 1064.
[47] *Mercy Hosp., Inc. v. Burwell,* 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[48] *Mercy*, 891 F.3d at 1068.
[49] IRF units are denoted by a "T" in the third digit of the provider number. *See, e.g., supra* note 44.

utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio, for IRF units. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Providers' appeal of the LIP adjustment and would dismiss that issue (including any LIP/IRF providers associated with that issue) from Case Nos. 15-0922GC and 15-3023G. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* would be controlling precedent because the Providers could bring suit in the D.C. Circuit.[50] Finally, to the extent that the Amount in Controversy for Case Nos. 15-0922GC and 15-3023GC includes the LIP payments, those amounts would be inaccurately overstated as the LIP issue has been dismissed. As discussed below, the DSH/IPPS providers remain in Case Nos. 15-0922GC and 15-3023GC.

C. Remaining IPPS/DSH Providers

The remaining IPPS/DSH participants that comprise the seven (7) group appeals within this EJR request have filed appeals involving fiscal years 2010-2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending *prior to December 31, 2008*, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[51] 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.[52] On August 21, 2008, new regulations governing the Board were effective.[53] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[54] In *Banner*, the provider filed its cost report in accordance with the applicable

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

[51] 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.).

[52] *Bethesda* at 1258-59.

[53] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

[54] 201 F. Supp. 3d 131 (D.D.C. 2016)

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.[55]

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 ("Ruling 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 Ruling 1727-R, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest. The Board finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. Consequently, the Board finds that it has jurisdiction over the remaining DSH Providers in these cases.

The Board has determined that the remaining IPPS/DSH participants involved with the instant EJR request are governed by Ruling 1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[56] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying IPPS/DSH providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

D. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued Ruling 1498-R on April 28, 2010 to authorize remands of pending appeals of the SSI data match issue in order to recalculate the associated SSI fractions based on a revised data match process.[57] The Secretary also stated in the Ruling that, for those hospitals whose cost reports had not yet been settled, the Secretary would recalculate the SSI fractions for those cost reports using the revised data match process to be published through rulemaking.[58] Contemporaneous with Ruling 1498-R,[59] the Secretary published a proposed IPPS rule[60] to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning

[55] *Banner* at 142.
[56] *See* 42 C.F.R. § 405.1837.
[57] CMS Ruling 1498-R at 27.
[58] *Id.* at 31.
[59] *Id.* at 5.
[60] 75 Fed. Reg. 23852, 24002-07.

on or after October 1, 2010. The Secretary adopted this proposed rule as part of the FY 2011 IPPS Final Rule in which the Secretary explained that:

> . . .we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[61]

Then she further announced:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[62]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[63]

While the Secretary did not incorporate the above new policy involving the revised data match process directly into the Code of Federal Regulations, it is clear from the language in the preamble to the FY 2011 IPPS Final Rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a binding data match process to be used by CMS in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2).

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C.

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[61] 75 Fed. Reg. at 50277.
[62] (Medicare) Enrollment Database.
[63] 75 Fed. Reg. at 50285.

§ 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[64] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation the published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the IPPS/DSH Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility.[65] As a result, the Board finds that EJR is appropriate for the issue for the calendar years under appeal in these cases.

E. 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 IPPS/DSH participants in these group appeals are entitled to a hearing before the Board;

2) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule 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 authority to decide the legal question of whether the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

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[64] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

[65] The Board notes that about half of the group cases covered by this EJR request involve fiscal years beginning on or after October 1, 2010 and, as such, Ruling 1498-R is ***not*** applicable or relevant to them. However, the remaining group cases ***do*** involve Ruling 1498-R (*see, e.g.,* Case Nos. 15-0667GC, 15-1863GC, 16-2313GC, and participant #1 in 16-1886GC) as these providers had a pre-10/1/2010 open cost report when Ruling 1498-R was issued and appealed from an original NPR. Notwithstanding, the Board notes that the Providers in this subset have *only* disputed the validity of the Uncodified SSI Data Matching Regulation which is applied to them via Ruling 1498-R as confirmed in the preamble to the FY 2011 IPPS Final Rule (75 Fed. Reg. at 50824-25) and have ***not*** raised any disputes or issues regarding the validity of Ruling 1498-R itself. *See* EJR request (including references to the Board's June 1, 2018 EJR determination in Case Nos. 13-10678, *et al.*); *compare* group appeal requests for all group appeals covered by this EJR decision. Accordingly, the Board finds that there are no substantive factual or legal differences among the cases covered by this EJR decision that would otherwise require the Board to bifurcate this EJR decision.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the IPPS/DSH Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

12/11/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Pam VanArsdale, NGS
Bryon Lamprect, WPS
Danene Hartley, NGS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Danene Hartley
National Government Services, Inc.
MP: INA 101-AF42
Indianapolis, IN 46206

RE: ***Untimely Filing – Reinstatement Request Denied***
Iroquois Memorial Hospital (Prov. No. 14-0167)
FYE 2019
Case No. 19-1165

Dear Mr. Roberts and Ms. Hartley:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal in response to your December 17, 201, request for reinstatement ("Reinstatement Request") of Case No. 19-1165 for Iroquois Memorial Hospital ("Iroquois" or "Provider"). As set forth below, the Board denies your request for reinstatement of this case.

Pertinent Facts:

On January 16, 2019, Iroquois filed an Individual Appeal Request for the fiscal year ending June 30, 2009 ("FY 2009"). In its appeal, Iroquois included a request to appeal from its Quality Reporting Payment Reduction for FY 2019.[1]

On February 14, 2019, the Board issued the Case Acknowledgement and Critical Due Dates Letter that included instructions for the provider to submit the preliminary position paper ("PPP") by September 13, 2019. The Board sent this letter to Michelle Fox via email, who at the time of the issuance was the designated Representative for Iroquois.[2] However, Iroquois failed to file its PPP by this deadline. Accordingly, on October 22, 2019, the Board dismissed the appeal due to Iroquois' failure to timely file its PPP.

On November 29, 2019, John Roberts, of Faegre Baker Daniels LLP filed a Request for Reinstatement, on behalf of Iroquois. However, at that time, the Board had no correspondence from Iroquois appointing such party as the Designated Representative on its behalf.[3] Accordingly, on December 11, 2019, the Board notified Iroquois it could not consider the request as Mr. Robers was not an authorized Representative.

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[1] Provider's Request for Hearing (Jan. 16, 2019).
[2] On December 9, 2019, Ms. Fox was still listed as the Designated Representative of Iroquois Memorial Hospital.
[3] *See* Provider's Request for Reinstatement (Nov. 29, 2019).

On December 17, 2019, Iroquois filed a Notice of Change of Representative, designating Mr. Roberts as the new representative.[4] Simultaneously, Mr. Roberts refiled the Reconsideration Request for Reinstatement of Appeal on behalf of Iroquois.

The Reconsideration Request notes that this past summer, Iroquois' management team, including Ms. Fox, the previous designated representative, was replaced by a new management team who learned of this appeal when the Board sent a letter to Iroquois in late October 2019 advising it that the Board was dismissing Iroquois' appeal because it failed to submit its PPP by September 13, 2019.[5] Iroquois apologized for missing the submission deadline due to an internal administrative error and respectfully asks the Board to reverse its October 22, 2019, dismissal decision and reinstate Iroquois' appeal.[6]

Board's Determination

The updated Board Rules, effective August 29, 2018, and superseding all previous rules and instructions, included an updated version of Board Rule 23. Board Rule 23 states that with the implementation of OH CDMS:

> [P]arties are now required to file the complete preliminary position paper with the narrative, listing of exhibits, and all exhibits. As the Board will now obtain a full copy of the preliminary position paper, which is required to have the fully developed position and identification of the controlling authority needed to support each issue in the appeal, final position papers will be optional for new appeals filed on or after the effective date of the rules. Final position papers are still mandatory for all appeals that were filed prior to that date.[7]

In concert with Rule 23, Board Rule 23.4 states that if the provider's PPP is not filed by the due date, *the case will be dismissed*.[8] To this end, the February 14, 2019 Acknowledgement and Critical Due Dates Notice issued by the Board set out the September 13, 2019 due date for the PPP and specified that "[i]f the Provider misses any of its due dates, the Board will dismiss the appeal."

Further, the Board issued an alert to all external users and stakeholders regarding the change in the Board rules, both by email blast as well as an alert posted on the "Current Alerts" section of the PRRB website. This alerted highlighted specific important changes including the requirement that a full PPP be filed: *"[r]equire the filing of the full preliminary position paper to*

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[4] *See* Provider's Notice of Change of Representative (Dec. 17, 2019).
[5] Provider's Reconsideration Request for Reinstatement (Dec. 17, 2019).
[6] *Id*. at 1.
[7] Board Rule 23 (Aug. 29, 2018).
[8] Board Rule 23.4.

both the opposing party and the Board (currently the preliminary position paper is only filed on the opposing party with only a cover letter to the Board)."[9]

Board Rule 25.1 specifies that the following content be included in PPPs:

> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.
>
> C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
>
> D. Provide a conclusion applying the material facts to the controlling authorities.[10]

Pursuant to 42 C.F.R. § 405.1868(b) and Board Rule 27, if a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice. Pursuant to 42 C.F.R. § 405.1801(a) and Board Rule 3, the date of filing is the date of receipt by the Board, or the date of delivery by a nationally-recognized next-day courier.

The Board previously found that the Provider did not comply with the Board rules regarding filing its PPP and, accordingly, dismissed the appeal on October 22, 2019. In this regard, the Board notes that Iroquois should have been well aware that the Board would dismiss the appeal if Iroquois failed to timely file its PPP in compliance with Board Rules and the instructions in the Case Acknowledgement and Critical Due Dates Letter dated February 14, 2019.

Board Rule 47 addresses reinstatements and specifies in Board Rule 47.1 that a provider may file a written motion for reinstatement within three years of from the date of the Board's decision to dismiss the issue(s)/case. Board Rule 47.1 further explains that the motion must include the reasons for reinstatement and sets forth the general rule that the Board will not reinstate a case if the provider was "at fault."

Additional guidance pertinent to this case is located in Board Rule 47.3. This Rule addresses reinstatement requests involving dismissals for failure to comply with Board procedures and specifies that "[g]enerally, administrative oversight, settlement negotiations, or a change in representative will not be considered good cause to reinstate." This Rule further states that "[i]f the dismissal was for failure to file with the Board a required position paper . . ., the motion for

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[9] *ALERT 15: Revised PRRB Rules (August 29, 2018)*, Current Alerts, PRRB Review (last visited Jan. 17, 2019), https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts.html.
[10] Board Rule 25.1

reinstatement *must*, ***as a prerequisite***, *include the required filing* before the Board will consider the motion."[11]

Again, Iroquois should have been well aware that the Board would dismiss the appeal if Iroquois failed to timely file its PPP in compliance with Board Rules and the instructions in the Case Acknowledgement and Critical Due Dates Letter dated February 14, 2019. Further, the finds that the Provider has failed to establish good cause for failing to timely file its PPP because Board Rule 47.3 is clear that the Board will not consider administrative error and change in representative (such as occurred here) as good cause to reinstate. Finally, Iroquois failed to meet the prerequisite in Board Rule 47.3 for Board consideration of its reinstatement request because it failed to correct its error by filing or otherwise including the required PPP with its Request for Reinstatement. Accordingly, the Board hereby denies the reinstatement request and the case remains closed.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

2/12/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, Federal Specialized Services

[11] (Emphasis added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
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Byron Lamprecht, Supervisor
Cost Report Appeals (J-5)
WPS Government Health Administrators
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RE: ***Denial of Transfer Requests***
The Nebraska Medical Center - Nebraska Medicine (Provider No. 28-0013)
FYE 06/30/2010
Case No. 14-1791

Dear Messrs. Ravindran and Lamprecht:

The Provider Reimbursement Review Board (the "Board") has reviewed the Provider Representative's October 29, 2019 Requests to Transfer Issue (Model Form D's) for the SSI Fraction Part C Days and Medicaid Fraction Part C Days issues in the above-captioned individual appeal. The pertinent facts and the Board's determination regarding these Transfer Requests are set forth below.

Pertinent Facts:

On January 17, 2014, The Nebraska Medical Center - Nebraska Medicine filed its individual appeal request for this appeal and it included only the following three issues: SSI Days, Dual Eligible Medi-Medi Days, and Organ Procurement.

On March 19, 2014, Quality Reimbursement Services, Inc. (QRS) timely filed purportedly on behalf of the Provider a request to add three (3) issues to the Provider's appeal: DSH Payment Medicaid Eligible Days, Outlier Payments-Fixed Loss Threshold, and RFBNA. Although the Provider did not officially appoint QRS as the authorized representative until September 12, 2019, the Provider did sign the certification page of the Add Issue Form. On January 16, 2015, the Provider *withdrew* both the DSH Payment Medicaid Eligible Days and the RFBNA issues. On September 24, 2014, the Provider transferred the Outlier issue to a group. Note that this decision does not address whether QRS was properly authorized to add on behalf of the Provider the sole remaining issue added on March 19, 2014 (*i.e.*, the Outlier issue).

On November 18, 2014, the Provider filed an appeal of the revised NPR ("RNPR"), which was incorporated into the subject case. The sole issue appealed from the RNPR was Dual Eligible Medi-Medi days. The audit adjustment showed that increased Medicaid Eligible Days was the issue revised for in the RNPR. The issue statement included with the RNPR appeal uses the same description of Dually Eligible Medi-Medi Days as that in the initial appeal request.

On September 9, 2019, the Provider *withdrew* the Organ Procurement cost issue.

On September 12, 2019, the Provider officially appointed QRS to be the authorized representative of the subject appeal. On September 13, 2019, QRS filed the Provider's final position paper ("FPP") identifying the following four issues in the appeal.

(1) Whether the correct SSI percentage was used in the DSH calculation,

(2) Whether the numerator of the "Medicaid fraction" properly includes all "eligible" Medicaid days, regardless of whether such days were paid days,

(3) Whether HMO/Medicare Plus Choice/Medicare Managed Care/Medicare Part C/ Medicare Advantage ("MA") Days were properly accounted for in the DSH calculation and

(4) Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare DSH calculation.

The FPP contains the first discussion of the Part C Days issues.[1] On October 29, 2019, QRS filed a request to transfer the two Part C issues to the following group appeals:

- Case 20-0208G – QRS CY 2010 DSH SSI Fraction Medicare Managed Care Part C Days (3) Group
- Case 20-0210G – QRS CY 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days (3) Group

The Transfer support included by QRS to verify that the issues were included in the appeal were copies of: (1) the initial appeal request (which did not include the Part C Days issues); and (2) the final position paper (which is the first mention of the Part C Days issue in the record).

On October 29, 2019, the Provider also requested to transfer the SSI Days issue to the group appeal under Case No. 20-0207G entitled "QRS CY 2010 DSH SSI Percentage (3) Group and, as such, the SSI days issue is not relevant to the Part C Days transfer requests at issue.[2] Rather, the transfer requests at issue purportedly relate to the Dual Eligible Days issue. The Dual Eligible Days issue concerns the Medicaid proxy and the appeal request described this issue as follows:

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[1] The Provider filed its preliminary position paper on October 1, 2014. *In accordance with Board Rules at that time*, the Provider was not required to file a full copy of the preliminary position paper. Consequently, only the cover page and List of Exhibits is available. The Medicare Contractor responded with its preliminary position paper on January 29, 2015. The Table of Contents included with the Medicare Contractor's preliminary position paper covered the three issues from the initial appeal request: SSI Percentage; Medicare Exhausted Benefits Days and Organ Acquisition Transplant Costs.

[2] The SSI Days issue was transferred to group appeals on October 29, 2019. As such, it is not relevant to the transfer request at issue in this letter. In this regard, the Board notes that, per the original appeal request, the SSI issue pertains only to understatement of the SSI ratio where the Provider asserted that the "***SSI ratio*** used in the as-filed cost report improperly ***excludes*** days attributable to patients who were entitled to Medicare Part A and entitled to Federal SSI, but whose days were not included in the numerator of the Medicare proxy (SSI ratio)" and where it needed MEDPAR data files in order to "*identify additional days attributable to patients who were entitled to both Medicare Part A and SSI benefits, which were* ***not being properly*** counted and ***included in the*** Medicare proxy and therefore, the published ***SSI ratio***." (Emphasis added.)

> The Provider contends that the Intermediary's determination *improperly **excluded*** [from the Medicaid proxy] *Medicaid days* attributable to patients who were dually eligible, but *who had exhausted Part A benefits and/or who were no longer entitled to Part A benefits for some other reason including, but not limited to, situations when Medicare is secondary to some other payer*. Furthermore, the Provider contends that the Intermediary's determination *improperly **excluded*** [from the Medicaid proxy] *Medicare days attributable to patients who were dually eligible, but not included in either the numerator or denominator **of the Medicare proxy***. ***At issue in the present dispute is the accuracy of*** the Centers for Medicare & Medicaid Services' ***(CMS) data*** and the Intermediary's interpretation of the applicable statute and implementing regulation. The Provider will be requesting its SSI data from CMS pursuant to the applicable regulation at 65 Fed. Reg. 50548 (August 18, 2000), entitled "Medicare Provider Analysis and Review (MEDPAR) HHS/HCFA/OIS 09-07-0009.
>
> ***Once [the data is] received from CMS***, ***the Provider*** will test in detail the MEDPAR data files which ***will identify additional days*** attributable to dually-eligible patients whose Medicare Part A benefits have been exhausted and/or additional days for which the patient is no longer entitled to Part A benefits for some other reason including, but not limited to, situations when Medicare is secondary to some other payer, which are not being counted in either the Medicare or Medicaid proxies. Furthermore, the Provider will identify additional days attributable to dually-eligible patients whose benefits have not exhausted, which are not being counted in either the Medicare or Medicaid proxies. ***This will be accomplished by matching dual eligible patients per the Hospital's inpatient discharge file and the data file furnished by CMS***. As the Hospital does not have access to the Social Security Administration's (SSA) SSI eligibility database, it will request verification with such by the appropriate authority. Further testing will be performed to confirm dual eligibility by verifying Medicaid eligibility through Medifax, Medicare eligibility through the Common Working File (CWF), and Medicare payment on the account through Patient Billing Histories.

On November 14, 2019, FSS filed a jurisdictional challenge over the Medicaid eligible issue, which also noted that the Part C issue was only raised in the Provider's FPP for the first time.[3]

[3] November 14, 2019 jurisdictional challenge page 2.

Board Determination:

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

42 C.F.R. § 405.1835(b) (2008) specifies that a provider's request for a Board hearing "must include" the following "content":

> [a]n explanation (for each specific item at issue . . .) of the the provider's dissatisfaction with the intermediary's . . . determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.

This regulation also confirms that the Board may dismiss an appeal if the hearing request fails to meet the "content" requirements.

Consistent with § 405.1835(b), Board Rules 7, 8 and 9 (effective July 2009) address the content of appeal requests and potential dismissal if they fail to comply:

> **Rule 7 - Issue Statement and Claim of Dissatisfaction**
>
> For each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction. (*See Rule 8 for special instructions regarding multi-component disputes*.)

7.1 - NPR or Revised NPR Adjustments

A. Identification of Issue: Give a concise issue statement *describing*

- the adjustment, including the adjustment number,
- why the adjustment is incorrect, and
- *how the payment should be determined differently.*

B. No Access to Data: 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.

7.2 - Self-Disallowed Items

A. Authority Requires Disallowance

If you claim that the item you are appealing was not claimed on the cost report because a regulation, manual, ruling, or some other legal authority predetermined that the item would not be allowed,

- *give a concise issue statement describing the self-disallowed item*
- *the reimbursement or payment sought for the item, and*
- *the authority that predetermined that the claim would be disallowed.*

B. No Access to Data

If the Provider elects to not 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.

C. Protest

For cost reporting periods ending on or after December 31, 2008, demonstrate how the Provider followed applicable procedures for filing a cost report under protest 42 CFR §405.1835(a)(1)(ii). . . .

Rule 8 - Framing Issues for Adjustments Involving Multiple Components

8.1 – General

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

8.2 - Disproportionate Share Cases (e.g., dual eligible, general assistance, charity care, *HMO days*, etc.)

8.3 - Bad Debts Cases (e.g., crossover, use of collection agency, 120-day presumption, indigence determination, etc.)

8.4 - Graduate Medical Education/Indirect Medical Education (e.g., managed care days, resident count, outside entity rotations, etc.)

8.5 - Wage Index (e.g., wage vs. wage-related, rural floor, data corrections, etc.)

Rule 9 - Board Acknowledgement of Appeals & Written Communications with the Board

You will receive an acknowledgement from the Board indicating that your appeal request has been received and the case number assigned. *If your appeal request does not comply with the filing requirements, the Board **may dismiss** your appeal* or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.[4]

Having reviewed the facts in the case, the Board finds that the Part C Days issue was not included in (1) *any* of the issue descriptions in the initial appeal request; (2) the request to add issues; or (3) the appeal of the revised NPR. The Provider had up to May 8, 2014[5] to add the Part C Days issue in the appeal but failed to do so. The written description of the Dual Eligible Days issue in the hearing request does not mention or identify Part C Days (*aka* Medicare Advantage or Medicare+Choice or HMO days). Rather, the first mention of the Part C Days issue was in the final position paper, which was filed five years after the initial appeal.

[4] (Italics and underline emphasis added.)
[5] The Provider had 180 days after receipt of the NPR dated August 6, 2013 to file an appeal with the Board. As receipt is presumed to be 5 days after the date of the NPR, the deadline to file an appeal was Friday, February 7, 2014. The Provider then had an additional 90 days from that date (*i.e.*, by Thursday, May 8, 2014) to file a request to add issues.

Moreover, the Provider's calculation of the amount in controversy for the Dual Eligible Days issue in the appeal request itself supports the Board's finding that the Dual Eligible Days issue as set forth in the Provider's appeal request does not otherwise encompass the Part C Days issue. In the appeal request, Provider gave the following description for the amount in controversy for the Dual Eligible Days issue: "$10,000 – *as the MedPar file has not yet been requested and analyzed*, the exact impact of this issue is ***unknown at this time***, however based [*sic* on] experience with previous fiscal years we can assuredly say the impact will be no less than $10,000."[6] However, the calculation of the Part C days issue would not require dependence on review of MedPAR data given that the relief sought by the Provider consistent with *Allina I* (as laid out in the Provider's FPP) is to have any Part C days that were counted in the SSI fraction be counted instead in the Medicaid fraction.[7] When the Provider filed its appeal request, the Provider should have been well aware of how many days were in dispute for the Part C days issue because the Provider is required to submit "no-pay bills" to the Medicare program for ***each*** Part C inpatient admission as discussed in the FY 2013 IPPS final rule published on August 31, 2012[8] and, as a consequence, the Provider's PS&R report for the fiscal year at issue would separately list out all relevant Part C days. Indeed, Part C days is listed in the Provider's FPP as an issue separate and apart from the Dual Eligible Days issue, and the Provider's FPP includes at Exhibit 2 its calculation of the estimated impact of the "Medicaid Fraction Managed Care Part C Days" issue on the Medicaid fraction *separate and apart from* the "Dual Eligible/Exhausted/MSP Days" issue.

In finding that the Part C issue should be separately listed, the Board notes that, beginning as early as 2010, there has been a clear distinction made between issue involving Part C Days, Medicare Exhausted and MSP Days, and SSI Days as confirmed by: (1) the March 2010 decision of the D.C. District Court decision in *Northeast Hospital Corp. v. Sebelius*, 699 F. Supp. 2d 81 (D.D.C. 2010) ("*Northeast Hospital*"); (2) the June 2010 decision of the Board in *King & Spalding Inclusion of Medicare Advantage Days in 2007 SSI Ratios v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D38 (June 29, 2010);[9] (3) the FY 2011 IPPS final rule published at 75 Fed. Reg. 50042 (Aug. 16 2010) readopting revisions to 42 C.F.R. § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B) that specifically relate to counting of Medicare Advantage days in the DSH calculation; and (4) the December 2010 decision of the D.C. District Court in *Allina Health Servs. v. Sebelius*, 756 F. Supp. 2d 61 (D.D.C. 2010) ("*Allina*") to stay the appeal of PRRB Dec.

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[6] (Emphasis added.)

[7] *See* Provider's FPP at 22 (stating: "Accordingly, MA days are not days for which patients are 'entitled to benefits under Part A.' As a result, these days should be excluded from the numerator and denominator of the Provider' Medicare fractions and included in the Providers' Medicaid fractions.")

[8] 77 Fed. Reg. 53258, 53410-11 (Aug. 31, 2012) (stating: (1) "On July 20, 2007, we issued Change Request 5647 instructing applicable hospitals to submit no pay bills for their Medicare Advantage patients *for FY 2007 forward* in order for these days to be captured in the DSH calculation."; (emphasis added); and (2) "we are finalizing our proposal that *hospitals that are required to submit no pay bills for the purpose of calculating the DPP* must also follow the time limits for filing claims, and the proposed amendments to the regulations at § 424.30 to incorporate these requirements" (emphasis added)).

[9] This Board decision was appealed and ultimately resulted in the D.C. Circuit's decision in *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).

No. 2010-D38 until the D.C. Circuit issued its decision in *Northeast Hospital*. Further, in 2011, D.C. Circuit issued its decision in *Northeast Hospital* (657 F.3d 1 (D.C. Cir. 2011)) and the D.C. District Court lifted its stay of *Allina* and then issued its decision in November 2012 at 904 F. Supp. 2d 75 (D.D.C. 2012). Finally, prior to May 2014, the D.C. Circuit affirmed the D.C. District Court's decision in *Allina* on April 1, 2014.[10] All of these actions and decisions regard the counting of Part C days in the SSI fraction confirm that Part C Days is a separate issue and that the Provider was on notice that it should have appealed the Part C days issue as a separate issue or added the Part C days issue on or prior to May 8, 2014.[11] Indeed, it is hard to accept under the Board's Rules that the appeal request encompasses the Part C days issue *given this history of litigation surrounding the counting of Part C days* ***and*** *the fact that the appeal request does not even mention or reference Medicare Part C days* (*aka* Medicare Advantage or Medicare+Choice or HMO days).

Finally, while QRS was not the Representative when the original appeal was filed, the record demonstrates that QRS was involved in this appeal early on and, in fact, purported to have authorization from the Provider to file a timely request to add issues to the appeal in March 2014.[12] By March 2014, QRS was well aware of Part C Days being considered a separate issue and, in this regard, the Board takes administrative notice that, prior to that date, QRS had already established with the Board numerous Part Days groups and individual appeals specifically identifying Part C Days as a separate and distinct issue. However, QRS failed to include the Part C Days issue in the March 2014 add issues request.

Based on the above discussion, the Board finds that the Provider's hearing request did not include the Part C Days issue as required for Board jurisdiction under 42 C.F.R. § 405.1835(b) (a hearing request must include an explanation of *each* specific item at issue) and Board Rule 8.1.A. (some issue may have multiple components, each contested component must be appealed as a separate issue and *described as* ***narrowly*** *as possible* and HMO or Medicare Part C is specifically identified as one of the components that must be separately identified). Accordingly, the Board dismisses both the SSI Fraction Part C Days issue *and* the Medicaid Fraction Part C Days issue (as briefed in the Provider's FPP) because these issues were not properly added to the appeal. As an issue must be properly pending in an individual appeal prior to transfer to a group appeal, the Board necessarily denies the Representative's requests to transfer the SSI Fraction Part C Days issue to Case No. 20-0208G and the Medicaid Fraction Part C Days issue to Case No. 20-0210G because neither of these issues was not properly raised in the individual appeal.

[10] 746 F.3d 1102 (D.C. Cir. 2014).
[11] The Medicare and Medicaid fractions of the SSI Part C Days issues are sometimes characterized as two separate issues.
[12] Again, note that this decision does not address whether QRS' action to add issues on March 14, 2014 was in fact proper and duly authorized by the Provider in compliance with both the regulations governing the Board and the Board's Rules.

Summary

The Board hereby dismisses the SSI Fraction Part C Days and the Medicaid Fraction Part C Days issues as they were not properly added to the individual appeal and, accordingly, denies the Provider's request to transfer those issue to Case Nos. 20-0208G and Case No. 20-0210G respectively.

The three remaining issues briefed in the Provider's FPP filed on September 13, 2019 are the SSI days issue, the Medicaid eligible days issue and the Medicaid exhausted and MSP days issue. ***The sole issue that remain pending in this appeal is the Medicaid exhausted and MSP days issue*** because the SSI days issue was transferred to 20-0207G entitled "QRS CY 2010 DSH SSI Percentage (3) Group on October 29, 2019 and the Provider already withdrawn the Medicaid eligible days issue through a Board filing received on January 30, 2015. *The Board is also considering whether on motion expedited judicial review is appropriate for the Medicaid exhausted and MSP days issue and will send notice under separate cover.*

Board Members Participating:
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

12/16/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Board Chair
Signed by: Clayton J. Nix -A

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination Hall Render DSH Dual Eligible SSI Patient Days Groups***
14-2563GC Promedica Health Sys. 2010 SSI Fraction Dual Eligible CIRP Group
15-0082GC Promedica Health Sys. 2011 DSH SSI Fraction Dual Eligible Days CIRP
15-1524GC Community HCS 2011 DSH SSI Ratio Dual Eligible Days CIRP Grp
15-2010GC Franciscan Alliance 2011 DSH SSI Fraction Dual Eligible Days CIRP
15-2417GC Promedica Health Sys. 2012 DSH SSI Fraction Dual Eligible Days CIRP
15-3007GC Thomas Health Sys. 2010 DSH SSI Fraction Dual Eligible Days CIRP Grp
16-0001GC Thomas Health Sys. 2011 DSH SSI Fraction Dual Eligible Days CIRP
16-0601GC Thomas Health Sys. 2012 DSH SSI Fraction Dual Eligible Days CIRP
16-2042GC Care New England 2013 DSH SSI Fraction Dual Eligible Days CIRP Grp

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' November 18, 2019 request for expedited judicial review ("EJR") (received November 19, 2019) in the above-referenced appeals. The Board's decision with respect EJR is set forth below.

Issue in Dispute

The issue for which the Board is considering EJR is:

> [W]hether the Providers' Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[1]

[1] Providers' EJR Request at 2. The appeal requests for Case Nos. 14-2563GC, 15-0082GC, 15-2010GC, 15-2417GC, 15-3007GC, and 16-0001GC included the challenge to the DSH fraction, but also and/or low income

Medicare Disproportionate Share Hospital (DSH) Payment Background

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

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[4]

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

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patient ("LIP") fraction for Inpatient Rehabilitation Facilities ("IRFs") and or IRF units, as applicable pursuant to 42 U.S.C. 1395ww(d)(5)(F).

[2] 42 C.F.R. Part 412.

[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).

[4] (Bold emphasis added and italics emphasis in original.)

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[5] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[6] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[7]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[8] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[9]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[10] and may terminate,[11] suspend[12] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[13] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[14]
2. The individual fails to apply for other benefits to which the individual may be entitled;[15]
3. The individual fails to participate in drug or alcohol addiction treatment;[16]
4. The individuals is absent from the United States for more than 30 days;[17] or
5. The individual becomes a resident of a public institutions or prison.[18]

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[5] 42 U.S.C. § 1382.
[6] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[7] 20 C.F.R. § 416.202.
[8] 42 U.S.C. § 426.
[9] 42 U.S.C. § 426-1.
[10] 20 C.F.R. § 416.204.
[11] 20 C.F.R. §§ 416.1331-1335.
[12] 20 C.F.R. §§ 416.1320-1330.
[13] 20 C.F.R. § 1320.
[14] 20 C.F.R. § 416.207.
[15] 20 C.F.R. § 416.210.
[16] 20 C.F.R. § 416.214.
[17] 20 C.F.R. § 416.215.
[18] 20 C.F.R. § 416.211.

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[19]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[20] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[21] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[22] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[23] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[24]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[25]

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[19] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[20] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[21] *Id.*
[22] *Id.*
[23] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[24] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[25] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[26] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[27] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[28]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[29] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[30]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[31] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[32] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02

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each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.*, Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[26] CMS-1498-R at 5.

[27] *Id.*

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

[29] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

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

[31] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

[32] *Id.* at 50280.

"accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[33] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[34] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[35]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e*., for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[36] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[37] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[38]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[39]

As a result of the Rulings, new regulation and data match process, CMS either calculated new SSI percentages or recalculated existing SSI percentages for each of the Providers for all of fiscal years at issue in these appeals.[40] All of the Providers in the groups covered by this EJR decision have appealed from *original* NPRs that used SSI percentages calculated based on the methodology articulated in the preamble to the FY 2011 IPPS Final Rule which includes using only the three SSI codes to denote SSI entitlement under 42 C.F.R. § 412.106(b)(2).

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[33] *Id.* at 50280-50281.
[34] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[35] *Id.* at 50285.
[36] CMS-1498-R at 6-7, 31.
[37] *Id.* at 28, 31.
[38] 75 Fed. Reg. at 24006.
[39] CMS-1498-R2 at 2, 6.
[40] The SSI ratios for FY 2009 and 2010 were published on March 16, 2012 and October 17, 2012, respectively. *See* https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

Providers' Request for EJR

The Providers assert that under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration ("SSA") for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[41]

The Providers note that in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[42] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the Medicare statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' DPP calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act.[43]

Decision of the Board

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

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[41] 75 Fed. Reg. at 50,275-286.
[42] *Id.* at 50,281.
[43] Pub. L. No. 108-173, § 951, 117 Stat. 2066, 2427 (2003).

A. Dismissal of LIP Issue from Case Nos. 14-2563GC, 15-0082GC, 15-2010GC, 15-2417GC, 15-3007GC, and 16-0001GC as there are no IRF/LIP providers in these cases.

The statement of the issue that accompanied the original hearing request in Case Nos. 14-2563GC, 15-0082GC, 15-2010GC, 15-2417GC, 15-3007GC, and 16-0001GC raised a question concerning both DSH as it relates to IPPS providers ("IPPS/DSH providers") and LIP as it relates to IRF providers ("IRF/LIP providers") of:

> Whether the Medicare Disproportionate Share Hospital (DSH) calculation was understated due to the failure of the Centers for Medicare & Medicaid Services (CMS) and the Fiscal Intermediary (FI) to properly include all Dual Eligible Days that are Medicare Non-Covered Days ("DE MNC Days"), which include but are not limited to Medicare Exhausted Days and MSP (Medicare Secondary Payor) Days were Medicare is secondary to another payor, in the numerator of the Medicare or Medicare fraction of the DSH percentage and/***or low income patient (LIP) fraction for Inpatient Rehabilitation Facilities (IRFs) and or IRF units*** as applicable pursuant to 42 U.S.C. § 1395ww(d)(5)(F).[44]

In the other cases containing this same statement of the issue, the LIP issue was transferred to a group appeal. A review of the Board's computer docketing system for Case Nos. 14-2563GC, 15-0082GC, 15-2010GC, 15-2417GC, 15-3007GC, and 16-0001GC could find no evidence of the Group Representative transferring the Dual Eligible Days issue related to the Inpatient Rehabilitation Facilities ("IRFs") to a LIP group appeal. Further, the final Schedules of Providers for Case Nos. 14-2563GC, 15-0082GC, 15-2010GC, 15-2417GC, 15-3007GC, and 16-0001GC do not separately list *any* IRF/LIP providers.[45] Therefore, the Board must conclude that there are no IRF/LIP providers participating in these groups and that the LIP issue is consequently moot. As such, the Board dismisses the LIP issue.

B. In the alternative, had there been IRF/LIP providers in Case Nos. 14-2563GC, 15-0082GC, 15-2010GC, 15-2417GC, 15-3007GC, and 16-0001GC, the Board would dismiss them.

a. Review of Dual Eligible Days in the LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals for the

[44] (Emphasis added.)
[45] IRF/LIP providers have unique provider numbers separate and distinct from the related IPPS/DSH provider.

District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* ("*Mercy*")[46] clarifies what is precluded from review in its analysis of this issue.

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[47] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court's decision[48] which concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The D.C. Circuit concluded that the statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[49]

b. Dismissal of the LIP Issue and any associated IRF/LIP providers from Case Nos. 14-2563GC, 15-0082GC, 15-2010GC, 15-2417GC, 15-3007GC, and 16-0001GC

As explained below, if there were IRF/LIP providers in Case Nos. 14-2563GC, 15-0082GC, 15-2010GC, 15-2417GC, 15-3007GC, and 16-0001GC, the Board would dismiss the Dual Eligible days issue for LIP (including any LIP/IRF providers associated with that issue) from Case Nos. 15-0922GC and 15-3023GC. Since jurisdiction over an issue is a prerequisite to grant a request for EJR, the Board would deny the EJR request as it relates to any LIP/IRF providers included in the request for EJR for the LIP issue under Case Nos. 14-2563GC, 15-0082GC, 15-2010GC, 15-2417GC, 15-3007GC, and 16-0001GC.

As previously noted, the Provider did not separately identify the IRF/LIP providers and IPPS/DSH providers on the final Schedule of Providers for Case Nos. 14-2563GC, 15-0082GC, 15-2010GC, 15-2417GC, 15-3007GC, and 16-0001GC.[50] Under the LIP issue, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio, for IRF units. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Providers' appeal of the LIP adjustment and would dismiss that issue (including any LIP/IRF providers associated with that issue) from Case Nos. 14-2563GC, 15-0082GC, 15-2010GC, 15-2417GC, 15-3007GC, and 16-0001GC. In making this finding, the Board notes that the Court of Appeals decision in *Mercy*

[46] 891 F.3d 1062 (June 8, 2018).
[47] *Id.* at 1064.
[48] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[49] *Mercy*, 891 F.3d at 1068.
[50] IRF units have a separate or unique provider number and are denoted by a "T" in the third digit of the provider number.

would be controlling precedent because the Providers could bring suit in the D.C. Circuit.[51] Finally, to the extent that the Amount in Controversy for Case Nos. 14-2563GC, 15-0082GC, 15-2010GC, 15-2417GC, 15-3007GC, and 16-0001GC includes the LIP payments, those amounts would be inaccurately overstated as the LIP issue has been dismissed. As discussed below, the DSH/IPPS providers remain in these appeals.

C. Remaining IPPS/DSH Providers

The remaining IPPS/DSH participants that comprise the nine (9) group appeals within this EJR request have filed appeals involving fiscal years 2010-2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending *prior to December 31, 2008*, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[52] 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.[53]

On August 21, 2008, new regulations governing the Board were effective.[54] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[55] 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

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

[52] 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.).

[53] *Bethesda* at 1258-59.

[54] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

[55] 201 F. Supp. 3d 131 (D.D.C. 2016)

regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[56]

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 ("Ruling 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 Ruling 1727-R, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest. The Board finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. Consequently, the Board finds that it has jurisdiction over the remaining DSH Providers in these cases.

The Board has determined that the remaining IPPS/DSH participants involved with the instant EJR request are governed by Ruling 1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[57] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying IPPS/DSH providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

D. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued Ruling 1498-R on April 28, 2010 to authorize remands of pending appeals of the SSI data match issue in order to recalculate the associated SSI fractions based on a revised data match process.[58] The Secretary also stated in the Ruling that, for those hospitals whose cost reports had not yet been settled, the Secretary would recalculate the SSI fractions for those cost reports using the revised data match process to be published through rulemaking.[59] Contemporaneous with Ruling 1498-R,[60] the Secretary published a proposed IPPS rule[61] to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the FY 2011 IPPS Final Rule in which the Secretary explained that:

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[56] *Banner* at 142.
[57] *See* 42 C.F.R. § 405.1837.
[58] CMS Ruling 1498-R at 27.
[59] *Id.* at 31.
[60] *Id.* at 5.
[61] 75 Fed. Reg. 23852, 24002-07.

> . . .we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[62]

Then she further announced:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[63]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[64]

While the Secretary did not incorporate the above new policy involving the revised data match process directly into the Code of Federal Regulations, it is clear from the language in the preamble to the FY 2011 IPPS Final Rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a binding data match process to be used by CMS in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2).

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C.

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[62] 75 Fed. Reg. at 50277.
[63] (Medicare) Enrollment Database.
[64] 75 Fed. Reg. at 50285.

§ 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[65] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation the published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility.[66] As a result, the Board finds that EJR is appropriate for the issue for the calendar years under appeal in these cases.

E. 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 IPPS/DSH participants in these group appeals are entitled to a hearing before the Board;

2) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule 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 authority to decide the legal question of whether the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule properly falls within the

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[65] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

[66] The Board notes that the majority of the cases involve fiscal years beginning on or after October 1, 2010 and, as such, Ruling 1498-R is not applicable or relevant to the majority of the cases. However, there are a subset of cases that involve Ruling 1498-R (*see, e.g.*, Case Nos.14-2563GC, 15-1524GC, 15-3007GC) where the providers had a pre-10/1/2010 open cost report when Ruling 1498-R was issued and appealed from an original NPR. Notwithstanding, the Board notes that the Providers in this subset have *only* disputed the validity of the Uncodified SSI Data Matching Regulation which is applied to them via Ruling 1498-R as confirmed in the preamble to the FY 2011 IPPS Final Rule (75 Fed. Reg. at 50824-25) and have ***not*** raised any disputes or issues regarding the validity of Ruling 1498-R itself. *See* EJR request (including references to the Board's June 1, 2018 EJR determination in Case Nos. 13-10678, *et al*.); *compare* group appeal requests for all group appeals covered by this EJR decision. Accordingly, the Board finds that there are no substantive factual or legal differences among the cases covered by this EJR decision that would otherwise require the Board to bifurcate this EJR decision.

provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the IPPS/DSH Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
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Robert A. Evarts, Esq.
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FOR THE BOARD:

12/16/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

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RE: Jurisdictional Determination
Inland Northwest Health Services (aka St. Luke's Rehabilitation Institute)
Provider No. 50-3025
FYE 12/31/2015
Case No. 18-0980

Dear Ms. Ponce and Mr. Bloom:

This case involves the Provider's appeal of its Medicare reimbursement for the fiscal year ending ("FYE") in 2015. The Provider Reimbursement Review Board ("Board") has reviewed the Provider's documentation in response to the Medicare Contractor's jurisdictional challenge and the June 8, 2018 decision of the U.S. Court of Appeals, District of Columbia Circuit ("D.C. Circuit") in *Mercy Hosp., Inc. v. Azar* ("*Mercy*"), on June 8, 2018.[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Low Income Patient ("LIP") Payments – Inclusion of Medicare Part C Days in the SSI Ratio issue and dismisses the instant appeal.

Pertinent Facts

The Board received the Provider's request for a hearing ("RFH") regarding a Notice of Program Reimbursement ("NPR") for the fiscal year ending December 31, 2015 ("FY 2015"). The Provider initially appealed seven issues. However, six of those issues were withdrawn or transferred to group appeals. The *sole* issue that remains pending in this appeal, and over which the Medicare Contractor challenged jurisdiction, is the LIP – Inclusion of Medicare Part C Days in the SSI Ratio issue.

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either: (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy* answers this question and clarifies what is shielded from review in its analysis of this issue.[2]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[3] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[4] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[5]

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[2] *Id*.
[3] *Id.* at 1064.
[4] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[5] *Mercy*, 891 F.3d at 1068.

In the instant appeal, the Provider seeks Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely the inclusion of Medicare Part C Days in the SSI Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeal that challenges this adjustment. In making this finding, the Board notes that the D.C. Circuit's decision in *Mercy* is controlling precedent because the Providers could bring suit in the D.C. Circuit.[6] As this is the sole remaining issue in the appeal, the Board hereby closes this case 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 Participating:

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Charlotte F. Benson, CPA
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Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

12/16/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, Federal Specialized Services

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination Hall Render DSH Dual Eligible SSI Patient Days Groups***

13-3753GC Community HCS 2010 DSH SSI Fraction Dual Eligible Days Group
14-3913GC McLaren Health Care 2010 DSH SSI Fraction Dual Eligible Days Group
14-3976GC Centegra Health 2011 DSH SSI Fraction Dual Eligible Days Group
14-4215GC McLaren Health Care 2011 DSH SSI Fraction Dual Eligible Days Group
14-4218GC Centegra Health 2010 DSH SSI Fraction Dual Eligible Days Group
15-2549GC McLaren Health 2013 DSH SSI Fraction Dual Eligible Days Group
15-3087GC Community Healthcare System 2012 DSH SSI Fraction Dual Eligible Days Group
17-2197GC Franciscan Alliance 2014 2010 DSH SSI Fraction Dual Eligible Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' November 25, 2019 request for expedited judicial review ("EJR") (received November 26, 2019) in the eight (8) above-referenced appeals.[1] The Board's decision with respect EJR is set forth below.

Issue in Dispute

The issue for which the Board is considering EJR is:

> [W]hether the Providers' Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI

[1] In the text of the EJR request (but not in the caption or introduction), the Provider Representative refers to two other cases: Case Nos. 13-1678GC and 13-2274GC. Specifically, he asserts that the Board has not yet issued EJR on them and, as a result, states that these two other cases are "included in this EJR request." The Provider Representative is mistaken. The Board has already addressed EJR for these other two case in its decision dated June 1, 2018 (which encompassed 21 group cases including these other two cases) and, as such, the Board will not address these other two cases in this EJR decision because the current request EJR is now moot for these two other cases.

> Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[2]

Medicare Disproportionate Share Hospital (DSH) Payment Background

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

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[5]

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[2] Providers' EJR Request at 2. The appeal requests for 14-3913GC, 14-3976GC, 14-4215GC, 15-2549GC and 15-3087GC included the challenge to the DSH fraction, but also and/or low income patient (LIP) fraction for Inpatient Rehabilitation Facilities (IRF's) and or IRF units, as applicable pursuant to 42 U.S.C. 1395ww(d)(5)(F).
[3] 42 C.F.R. Part 412.
[4] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[5] (Bold emphasis added and italics emphasis in original.)

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

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[6] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[7] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[8]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[9] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[10]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[11] and may terminate,[12] suspend[13] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[14] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[15]
2. The individual fails to apply for other benefits to which the individual may be entitled;[16]
3. The individual fails to participate in drug or alcohol addiction treatment;[17]
4. The individuals is absent from the United States for more than 30 days;[18] or
5. The individual becomes a resident of a public institutions or prison.[19]

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[6] 42 U.S.C. § 1382.
[7] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[8] 20 C.F.R. § 416.202.
[9] 42 U.S.C. § 426.
[10] 42 U.S.C. § 426-1.
[11] 20 C.F.R. § 416.204.
[12] 20 C.F.R. §§ 416.1331-1335.
[13] 20 C.F.R. §§ 416.1320-1330.
[14] 20 C.F.R. § 1320.
[15] 20 C.F.R. § 416.207.
[16] 20 C.F.R. § 416.210.
[17] 20 C.F.R. § 416.214.
[18] 20 C.F.R. § 416.215.
[19] 20 C.F.R. § 416.211.

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[20]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[21] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[22] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[23] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[24] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[25]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[26]

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[20] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[21] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[22] *Id.*
[23] *Id.*
[24] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[25] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[26] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3)

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[27] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[28] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[29]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[30] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[31]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[32] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[33] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI

"the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.*, Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[27] CMS-1498-R at 5.

[28] *Id.*

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

[30] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

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

[32] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

[33] *Id.* at 50280.

benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[34] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[35] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[36]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e*., for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[37] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[38] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[39]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[40]

As a result of the Rulings, new regulation and data match process, CMS either calculated new SSI percentages or recalculated existing SSI percentages for each of the Providers for all of fiscal years at issue in these appeals.[41] All of the Providers in the groups covered by this EJR decision have appealed from *original* NPRs that used SSI percentages calculated based on the methodology articulated in the preamble to the FY 2011 IPPS Final Rule which includes using only the three SSI codes to denote SSI entitlement under 42 C.F.R. § 412.106(b)(2).

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[34] *Id.* at 50280-50281.
[35] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[36] *Id.* at 50285.
[37] CMS-1498-R at 6-7, 31.
[38] *Id.* at 28, 31.
[39] 75 Fed. Reg. at 24006.
[40] CMS-1498-R2 at 2, 6.
[41] The SSI ratios for FY 2009 and 2010 were published on March 16, 2012 and October 17, 2012, respectively. *See* https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

Providers' Request for EJR

The Providers assert that under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from SSA for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[42]

The Providers note that in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[43] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the Medicare statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' DPP calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act.[44]

[42] 75 Fed. Reg. at 50,275-286.
[43] *Id.* at 50,281.
[44] Pub. L. No. 108-173, § 951, 117 Stat. 2066, 2427 (2003).

Decision of the Board

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

A. Dismissal of LIP Issue from Case Nos. 14-3913GC, 14-3976GC, 14-4215GC, 15-2549GC and 15-3087GC as there are no IRF/LIP providers in these cases.

The statement of the issue that accompanied the original hearing request in Case Nos. 14-3913GC, 14-3976GC, 14-4215GC, 15-2549GC and 15-3087GC raised a question concerning both DSH as it relates to IPPS providers ("IPPS/DSH providers") and LIP as it relates to IRF providers ("IRF/LIP providers") of:

> Whether the Medicare Disproportionate Share Hospital (DSH) calculation was understated due to the failure of the Centers for Medicare & Medicaid Services (CMS) and the Fiscal Intermediary (FI) to properly include all Dual Eligible Days that are Medicare Non-Covered Days ("DE MNC Days"), which include but are not limited to Medicare Exhausted Days and MSP (Medicare Secondary Payor) Days were Medicare is secondary to another payor, in the numerator of the Medicare or Medicare fraction of the DSH percentage and/***or low income patient (LIP) fraction for Inpatient Rehabilitation Facilities (IRFs) and or IRF units*** as applicable pursuant to 42 U.S.C. § 1395ww(d)(5)(F).[45]

Case No. 14-3931GC covers fiscal year 2010 and the original Schedule of Providers filed with this case listed three (3) providers – two (2) IPPS/DSH providers and an IRF/LIP provider.[46] Case Nos. 14-3976GC and 14-4215GC cover fiscal year 2011 and the original schedule of Providers filed for these cases each included one IRF/LIP provider as well as one or more IPPS/DSH providers. Case Nos. 15-3087GC and 15-2549GC cover fiscal years 2012 and 2013 respectively and the original Schedule of Providers for each of these cases only included two (2) IPPS/DSH providers.

In the other cases containing this same statement of the issue, the LIP issue was transferred to a group appeal. A review of the Board's computer docketing system for Case Nos. 14-3913GC, 14-3976GC, 14-4215GC, 15-2549GC and 15-3087GC could find no evidence of the Group

[45] (Emphasis added.)

[46] Each IRF/LIP provider receives its own unique provider number separate and apart from any associated IPPS/DSH provider. There is a "T" in the third digit of provider numbers assigned to IRF/LIP providers. For example in Case No. 14-3913GC, the two IPPS/DSH providers on the original Schedule of Providers were: (1) McLaren-Flint (Provider No. 23-0141); (2) McLaren Greater Lansing (Provider No. 23-0167). The sole IRF/LIP provider listed was for McLaren Flint under Provider No. 23-**T**141.

Representative transferring the Dual Eligible Days issue related to the Inpatient Rehabilitation Facilities ("IRFs") to a LIP group appeal. Further, the final Schedule of Providers for Case Nos. 14-3913GC, 14-3976GC, 14-4215GC, 15-2549GC and 15-3087GC did not list any IRF/LIP providers and only included IPPS/DSH providers. Therefore, the Board must conclude that there are no IRF/LIP providers and that the LIP issue is consequently moot in these cases. As such, the Board dismisses the LIP issue for these cases.

B. In the alternative, had there been IRF/LIP providers in Case Nos. 14-3913GC, 14-3976GC, 14-4215GC, 15-2549GC and 15-3087GC, the Board would dismiss them.

a. Review of Dual Eligible Days in the LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals for the District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* ("*Mercy*")[47] clarifies what is precluded from review in its analysis of this issue.

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[48] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court's decision[49] which concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The D.C. Circuit concluded that the statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[50]

b. Dismissal of the LIP Issue and any associated IRF/LIP providers from Case Nos. 14-3913GC, 14-3976GC, 14-4215GC, 15-2549GC and 15-3087GC

As explained below, if there were IRF/LIP providers in Case Nos. 14-3913GC, 14-3976GC, 14-4215GC, 15-2549GC and 15-3087GC, the Board would dismiss the Dual Eligible days issue for LIP (including any LIP/IRF providers associated with that issue) from the appeals. Since jurisdiction over an issue is a prerequisite to grant a request for EJR, the Board would deny the

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[47] 891 F.3d 1062 (June 8, 2018).
[48] *Id*. at 1064.
[49] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[50] *Mercy*, 891 F.3d at 1068.

EJR request as it relates to any LIP/IRF providers included in the request for EJR for the LIP issue under Case Nos. 14-3913GC, 14-3976GC, 14-4215GC, 15-2549GC and 15-3087GC.

As previously noted, the Provider did not separately identify the IRF/LIP providers and IPPS/DSH providers on the final Schedule of Providers for Case Nos. 14-3913GC, 14-3976GC, 14-4215GC, 15-2549GC and 15-3087GC.[51] Under the LIP issue, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio, for IRF units. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Providers' appeal of the LIP adjustment and would dismiss that issue (including any LIP/IRF providers associated with that issue) from the appeals. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* would be controlling precedent because the Providers could bring suit in the D.C. Circuit.[52] Finally, to the extent that the Amount in Controversy for Case Nos. 14-3913GC, 14-3976GC, 14-4215GC, 15-2549GC and 15-3087GC includes the LIP payments, those amounts would be inaccurately overstated as the LIP issue has been dismissed. As discussed below, the DSH/IPPS providers remain in Case Nos. 14-3913GC, 14-3976GC, 14-4215GC, 15-2549GC and 15-3087GC.

C. Jurisdictional Determination on the Remaining IPPS/DSH Providers

The remaining IPPS/DSH participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2010-2014.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending *prior to December 31, 2008*, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[53] 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.[54]

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[51] IRF units are denoted by a "T" in the third digit of the provider number. *See, e.g., supra* note 46.
[52] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).
[53] 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.).
[54] *Bethesda* at 1258-59.

On August 21, 2008, new regulations governing the Board were effective.[55] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[56] 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.[57]

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 ("Ruling 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 Ruling 1727-R, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest. The Board finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. Consequently, the Board finds that it has jurisdiction over the remaining IPPS/DSH Providers in these cases.

D. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued Ruling 1498-R on April 28, 2010 to authorize remands of pending appeals of the SSI data match issue in order to recalculate the associated SSI fractions based on a revised data match process.[58] The Secretary also stated in the Ruling that, for those hospitals whose cost reports had not yet been settled, the Secretary would recalculate the SSI fractions for those cost reports using the revised data match process to be published through rulemaking.[59] Contemporaneous with Ruling 1498-R,[60] the Secretary published a proposed IPPS rule[61] to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning

[55] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[56] 201 F. Supp. 3d 131 (D.D.C. 2016)
[57] *Banner* at 142.
[58] CMS Ruling 1498-R at 27.
[59] *Id.* at 31.
[60] *Id.* at 5.
[61] 75 Fed. Reg. 23852, 24002-07.

on or after October 1, 2010. The Secretary adopted this proposed rule as part of the FY 2011 IPPS Final Rule in which the Secretary explained that:

> . . .we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[62]

Then she further announced:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[63]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[64]

While the Secretary did not incorporate the above new policy involving the revised data match process directly into the Code of Federal Regulations, it is clear from the language in the preamble to the FY 2011 IPPS Final Rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a binding data match process to be used by CMS in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2).

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C.

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[62] 75 Fed. Reg. at 50277.
[63] (Medicare) Enrollment Database.
[64] 75 Fed. Reg. at 50285.

§ 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[65] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation the published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the IPPS/DSH Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility.[66] As a result, the Board finds that EJR is appropriate for the issue for the calendar years under appeal in these cases.

E. 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 IPPS/DSH participants in these group appeals are entitled to a hearing before the Board;

2) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule 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 authority to decide the legal question of whether the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

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[65] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

[66] The Board notes that the majority of the cases covered by this EJR request involve fiscal years beginning on or after October 1, 2010 and, as such, Ruling 1498-R is not applicable or relevant to the majority of the cases. However, there are a subset of cases that involve Ruling 1498-R (*see, e.g.*, Case Nos.13-3753GC, 14-3913GC, 14-4218GC) where the providers had a pre-10/1/2010 open cost report when Ruling 1498-R was issued and appealed from an original NPR. Notwithstanding, the Board notes that the Providers in this subset have *only* disputed the validity of the Uncodified SSI Data Matching Regulation which was finalized in the FY 2011 IPPS Final Rule and is applied to them via Ruling 1498-R as confirmed in the preamble to the FY 2011 IPPS Final Rule (75 Fed. Reg. at 50824-25) and have ***not*** raised any disputes or issues regarding the validity of Ruling 1498-R itself. *See* EJR request (including references to the Board's June 1, 2018 EJR determination in Case Nos. 13-10678, *et al*.); *compare* group appeal requests for all group appeals covered by this EJR decision. Accordingly, the Board finds that there are no unique 1498-R legal issues raised that would necessarily only pertain to this subset of cases and, as such, that there are no substantive factual or legal differences among ***all*** of the cases covered by this EJR decision that would otherwise require the Board to bifurcate this EJR decision.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the IPPS/DSH Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

12/19/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS
Danene Hartley, NGS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

December 19, 2019

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

Byron Lamprecht
Supervisor - Cost Report Appeals
WPS Government Health Administrators (J-5)
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: Dismissal of Optional Group That Does Not Meet Minimum Participant Requirements
QRS CY 2010 DSH SSI Fraction Medicare Managed Care Part C Days (3) Group
PRRB Case Number: 20-0208G

Dear Mr. Ravindran and Mr. Lamprecht:

On December 16, 2019, the Provider Reimbursement Review Board (the Board) dismissed the SSI Fraction Part C Days and the Medicaid Fraction Part C Days issues from the individual appeal for the Nebraska Medical Center-Nebraska Medicine (case number 14-1791). In the December 16, 2019 letter, the Board found that the Part C Days issues were not included in the initial appeal, the appeal of the revised NPR, nor were they timely added to the case. Consequently, the Provider's request to transfer the SSI Fraction Medicare Managed Care Part C Days issue to the subject group was also denied. Pursuant to 42 C.F.R. § 405.1837(b)(2) and Board Rule 12.6.2, "[o]ptional groups must have a minimum of two different providers, both at inception and at full formation of the group." Further, in the Commentary preceding Board Rule 12.2, the Board explains that group appeals filed through OH CDMS being formed solely with transfers, may be established with no participating providers. "In such cases, the providers must be transferred immediately following the establishment of the group case in order to fulfill the regulatory requirement for the minimum numbers of providers per Rule 12.6. The Board will close all group cases that do not meet the minimum participant requirements." Because the subject optional group appeal, which was filed on October 23, 2019, has no participants, the Board hereby closes case number 20-0208G.

Board Members Participating:
Clayton J. Nix, Esq.
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Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
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FOR THE BOARD:

Clayton J. Nix, Esq.
Chair

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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December 19, 2019

James Ravindran
President
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Supervisor - Cost Report Appeals
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Omaha, NE 68164

RE: Dismissal of Optional Group That Does Not Meet Minimum Participant Requirements
QRS CY 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days (3) Group
PRRB Case Number: 20-0210G

Dear Mr. Ravindran and Mr. Lamprecht:

On December 16, 2019, the Provider Reimbursement Review Board (the Board) dismissed the SSI Fraction Part C Days and the Medicaid Fraction Part C Days issues from the individual appeal for the Nebraska Medical Center-Nebraska Medicine (case number 14-1791). In the December 16, 2019 letter, the Board found that the Part C Days issues were not included in the initial appeal, the appeal of the revised NPR, nor were they timely added to the case. Consequently, the Provider's request to transfer the Medicaid Fraction Medicare Managed Care Part C Days issue to the subject group was also denied. Pursuant to 42 C.F.R. § 405.1837(b)(2) and Board Rule 12.6.2, "[o]ptional groups must have a minimum of two different providers, both at inception and at full formation of the group." Further, in the Commentary preceding Board Rule 12.2, the Board explains that group appeals filed through OH CDMS being formed solely with transfers, may be established with no participating providers. "In such cases, the providers must be transferred immediately following the establishment of the group case in order to fulfill the regulatory requirement for the minimum numbers of providers per Rule 12.6. The Board will close all group cases that do not meet the minimum participant requirements." Because the subject optional group appeal, which was filed on October 23, 2019, has no participants, the Board hereby closes case number 20-0210G.

Board Members Participating:
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FOR THE BOARD:

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Chair

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Maureen O'Brien Griffin, Esq.
Hall, Render, Killian, Heath & Lyman
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RE: **EJR Determination Hall Render DSH Dual Eligible SSI Patient Days Groups**
15-1705GC Indiana University Health 2010 DSH SSI Fraction Dual Eligible Days Group
15-3470GC Community Healthcare System 2013 DSH SSI Fraction Dual Eligible Days Group
16-2371GC Truman 2008 SSI Fraction Dual Eligible Days Group
16-2372GC Truman 2007 SSI Fraction Dual Eligible Days Group
17-0243GC Truman Medical Center 2014 DSH Dual Eligible Days Group
17-1850GC IU Health 2014 DSH SSI Fraction Dual Eligible Days Group
17-1911GC Community Healthcare System 2015 DSH SSI Fraction Dual Eligible Days Group
17-2062GC Truman Medical Center 2015 DSH Medicare Dual Eligible Days Group
17-2316GC Thomas Health System 2014 DSH SSI Fraction Dual Eligible Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' December 5, 2019 request for expedited judicial review ("EJR") (received December 6, 2019) in the above-referenced appeals. The Board's decision with respect EJR is set forth below.

Issue in Dispute

The issue for which the Board is considering EJR is:

> [W]hether the Providers' Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI

> Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[1]

Medicare Disproportionate Share Hospital (DSH) Payment Background

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

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

[1] Providers' EJR Request at 2. The appeal requests for both 15-1705GC and 15-3470GC included the challenge to the DSH fraction, but also and/or low income patient (LIP) fraction for Inpatient Rehabilitation Facilities (IRF's) and or IRF units, as applicable pursuant to 42 U.S.C. 1395ww(d)(5)(F). In case number 15-1705GC the LIP issue for the rehabilitation subprovider, Indiana University Ball Memorial (provider no. 15-T089) was transferred to case number 17-1443G and is no longer part of that group appeal. Therefore only 15-3704GC has a LIP challenging remaining.
[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).

> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[4]

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

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[5] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[6] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[7]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[8] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[9]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[10] and may terminate,[11] suspend[12] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[13] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[14]
2. The individual fails to apply for other benefits to which the individual may be entitled;[15]

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

3. The individual fails to participate in drug or alcohol addiction treatment;[16]
4. The individuals is absent from the United States for more than 30 days;[17] or
5. The individual becomes a resident of a public institutions or prison.[18]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[19]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[20] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[21] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[22] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[23] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[24]

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

[16] 20 C.F.R. § 416.214.
[17] 20 C.F.R. § 416.215.
[18] 20 C.F.R. § 416.211.
[19] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[20] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[21] *Id.*
[22] *Id.*
[23] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[24] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.

basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[25]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[26] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[27] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[28]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[29] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[30]

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[25] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.*, Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[26] CMS-1498-R at 5.

[27] *Id.*

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

[29] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

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

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[31] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[32] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[33] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[34] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[35]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[36] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[37] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[38]

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eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").

[31] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

[32] *Id.* at 50280.

[33] *Id.* at 50280-50281.

[34] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.

[35] *Id.* at 50285.

[36] CMS-1498-R at 6-7, 31.

[37] *Id.* at 28, 31.

[38] 75 Fed. Reg. at 24006.

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[39]

As a result of the Rulings, new regulation and data match process, CMS either calculated new SSI percentages or recalculated existing SSI percentages for each of the Providers for all of fiscal years at issue in these appeals.[40] All of the Providers in the groups covered by this EJR decision have appealed from *original* NPRs that used SSI percentages calculated based on the methodology articulated in the preamble to the FY 2011 IPPS Final Rule which includes using only the three SSI codes to denote SSI entitlement under 42 C.F.R. § 412.106(b)(2).

Providers' Request for EJR

The Providers assert that under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from SSA for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[41]

The Providers note that in administering the SSI program, SSA assigns each beneficiary a PSC. The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[42] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their

[39] CMS-1498-R2 at 2, 6.
[40] The SSI ratios for FY 2009 and 2010 were published on March 16, 2012 and October 17, 2012, respectively. *See* https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[41] 75 Fed. Reg. at 50,275-286.
[42] *Id.* at 50,281.

DSH adjustments were calculated in accordance with the Medicare statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' DPP calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act.[43]

Decision of the Board

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

A. Dismissal of LIP Issue from Case No. 15-3470GC as there are no IRF/LIP providers in this case

The statement of the issue that accompanied the original hearing request in Case No. 15-3470GC raised a question concerning both DSH as it relates to IPPS providers ("IPPS/DSH providers") and LIP as it relates to IRF providers ("IRF/LIP providers") of:

> Whether the Medicare Disproportionate Share Hospital (DSH) calculation was understated due to the failure of the Centers for Medicare & Medicaid Services (CMS) and the Fiscal Intermediary (FI) to properly include all Dual Eligible Days that are Medicare Non-Covered Days ("DE MNC Days"), which include but are not limited to Medicare Exhausted Days and MSP (Medicare Secondary Payor) Days were Medicare is secondary to another payor, in the numerator of the Medicare or Medicare fraction of the DSH percentage and/***or low income patient (LIP) fraction for Inpatient Rehabilitation Facilities (IRFs) and or IRF units*** as applicable pursuant to 42 U.S.C. § 1395ww(d)(5)(F).[44]

Case No. 15-3470GC covered fiscal year 2013 and the original Schedule of Providers filed with this case listed three IPPS/DSH providers, but did not identify any IRF subproviders. Further, the final Schedule of Providers for Case No. 15-3470GC did not list any IRF/LIP providers and only included the same three (3) IPPS/DSH providers. Therefore, the Board must conclude that there are no IRF/LIP providers and that the LIP issue is consequently moot. As such, the Board dismisses the LIP issue.

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[43] Pub. L. No. 108-173, § 951, 117 Stat. 2066, 2427 (2003).
[44] (Emphasis added.)

B. In the alternative, had there been IRF/LIP providers in Case No. 15-3470GC the Board would dismiss them.

1. Review of Dual Eligible Days in the LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals for the District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* ("*Mercy*")[45] clarifies what is precluded from review in its analysis of this issue.

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[46] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court's decision[47] which concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The D.C. Circuit concluded that the statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[48]

2. Dismissal of the LIP Issue and any associated IRF/LIP providers from Case No. 15-3470GC

As explained below, if there were IRF/LIP providers Case No.15-3470GC, the Board would dismiss the Dual Eligible days issue for LIP (including any LIP/IRF providers associated with that issue) from Case Nos. 15-3470GC. Since jurisdiction over an issue is a prerequisite to grant a request for EJR, the Board would deny the EJR request as it relates to any LIP/IRF providers included in the request for EJR for the LIP issue under Case No. 15-3470GC.

As previously noted, the Provider did not separately identify the IRF/LIP providers and IPPS/DSH providers on the final Schedule of Providers for Case No. 15-3470GC.[49] Under the LIP issue, the Providers seek Board review of one of the components utilized by the Medicare

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[45] 891 F.3d 1062 (June 8, 2018).
[46] *Id.* at 1064.
[47] *Mercy Hosp., Inc. v. Burwell,* 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[48] *Mercy*, 891 F.3d at 1068.
[49] IRF units are denoted by a "T" in the third digit of the provider number.

Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio, for IRF units. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Providers' appeal of the LIP adjustment and would dismiss that issue (including any LIP/IRF providers associated with that issue) from Case No. 15-3470GC. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* would be controlling precedent because the Providers could bring suit in the D.C. Circuit.[50] Finally, to the extent that the Amount in Controversy for Case No. 15-3470GC includes the LIP payments, those amounts would be inaccurately overstated as the LIP issue has been dismissed. As discussed below, the DSH/IPPS providers remain in Case No. 15-3470GC.

C. Remaining IPPS/DSH Providers

The remaining IPPS/DSH participants that comprise the nine (9) group appeals within this EJR request have filed appeals involving fiscal years 2007, 2008, 2010, 2013-2015.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending *prior to December 31, 2008*, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[51] 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.[52] On August 21, 2008, new regulations governing the Board were effective.[53] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[54] In *Banner*, the provider filed its cost report in accordance with the applicable

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

[51] 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.).

[52] *Bethesda* at 1258-59.

[53] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

[54] 201 F. Supp. 3d 131 (D.D.C. 2016)

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.[55]

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 ("Ruling 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 Ruling 1727-R, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest. The Board finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. Consequently, the Board finds that it has jurisdiction over the remaining DSH Providers in these cases.

The Board has determined that the remaining IPPS/DSH participants involved with the instant EJR request are governed by the decision in *Bethesda and* Ruling 1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[56] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying IPPS/DSH providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

D. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued Ruling 1498-R on April 28, 2010 to authorize remands of pending appeals of the SSI data match issue in order to recalculate the associated SSI fractions based on a revised data match process.[57] The Secretary also stated in the Ruling that, for those hospitals whose cost reports had not yet been settled, the Secretary would recalculate the SSI fractions for those cost reports using the revised data match process to be published through rulemaking.[58]

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[55] *Banner* at 142.
[56] *See* 42 C.F.R. § 405.1837.
[57] CMS Ruling 1498-R at 27.
[58] *Id.* at 31.

Contemporaneous with Ruling 1498-R,[59] the Secretary published a proposed IPPS rule[60] to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the FY 2011 IPPS Final Rule in which the Secretary explained that:

> . . .we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[61]

Then she further announced:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[62]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[63]

While the Secretary did not incorporate the above new policy involving the revised data match process directly into the Code of Federal Regulations, it is clear from the language in the preamble to the FY 2011 IPPS Final Rule, as set forth above, that the Secretary intended to bind

[59] *Id.* at 5.
[60] 75 Fed. Reg. 23852, 24002-07.
[61] 75 Fed. Reg. at 50277.
[62] (Medicare) Enrollment Database.
[63] 75 Fed. Reg. at 50285.

the regulated parties and establish a binding data match process to be used by CMS in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2).

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[64] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation the published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the IPPS/DSH Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility.[65] As a result, the Board finds that EJR is appropriate for the issue for the calendar years under appeal in these cases.

E. 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 IPPS/DSH participants in these group appeals are entitled to a hearing before the Board;

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

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

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[64] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

[65] The Board notes that several of the group cases covered by this EJR request involve fiscal years beginning on or after October 1, 2010 and, as such, Ruling 1498-R is ***not*** applicable or relevant to them. However, the remaining group cases ***do*** involve Ruling 1498-R (*see, e.g.,* Case Nos.16-2371GC and 16-2372GC) as these providers had a pre-10/1/2010 open cost report when Ruling 1498-R was issued and appealed from an original NPR. Notwithstanding, the Board notes that the Providers in this subset have *only* disputed the validity of the Uncodified SSI Data Matching Regulation which is applied to them via Ruling 1498-R as confirmed in the preamble to the FY 2011 IPPS Final Rule (75 Fed. Reg. at 50824-25) and have ***not*** raised any disputes or issues regarding the validity of Ruling 1498-R itself. *See* EJR request (including references to the Board's June 1, 2018 EJR determination in Case Nos. 13-10678, *et al*.); *compare* group appeal requests for all group appeals covered by this EJR decision. Accordingly, the Board finds that there are no substantive factual or legal differences among the cases covered by this EJR decision that would otherwise require the Board to bifurcate this EJR decision.

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

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the IPPS/DSH Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

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FOR THE BOARD:

12/30/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Byron Lamprect, WPS
Laurie Polson, Palmetto GBA c/o NGS
Wilson Leong, FSS