**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: N2-19-25
Baltimore, MD 21244
410-786-2671

**Via Electronic Delivery**

Nicholas Putnam
Strategic Reimbursement Group, LLC
360 West Butterfield Rd., Ste. 310
Elmhurst, IL 60126

**RE:** ***Jurisdictional Determination***
Our Lady of the Resurrection (Prov. No. 14-0251; FYE 6/30/2007)
*As a participant in* SRI Presence 2007 Medicare Fraction Part C Days CIRP Group
Case No. 14-1397GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board ("Board") has reviewed the SRI Presence 2007 Medicare Fraction Part C Days CIRP Group. The issue in this group is governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R. Under the terms of this Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020). However, prior to issuing a remand for the group, the Board finds a jurisdictional impediment with regard to one of the participants, Our Lady of the Resurrection. The background of the case, the pertinent facts with regard to this participant and the Board's determination are set forth below.

**Background**:

The SRI Presence 2007 Medicare Fraction Part C CIRP group appeal request was filed by Strategic Reimbursement Group ("SRG"), formerly Strategic Reimbursement Inc. ("SRI"), on December 5, 2013. On November 13, 2020, SRG requested Expedited Judicial Review ("EJR") of the group. The Board denied the EJR on November 24, 2020 because it lacked jurisdiction over the Part C Days issue per CMS Ruling 1739-R. The Schedule of Providers for the group was filed on April 13, 2020. Subsequently, on January 11, 2020 the Representative withdrew 2 of the participating providers (Prov. Nos. 14-0155 and 14-0217).

In reviewing the jurisdiction documents for the remaining participants in the group in order to process the remand, it was noted that all but one of the participants (Provena United Samartian, Prov. No.14-0093) are appealing from revised NPRs, and that one of the revised NPR participants, Our Lady of The Resurrection, did not have a change to the SSI Percentage on its revised NPR audit adjustment report. The pertinent facts with regard to ***Our Lady of The Resurrection*** below.

**Pertinent Facts:**

The individual appeal for Our Lady of the Resurrection Medical Center was filed by SRI on August 23, 2013. The appeal was filed from a revised NPR dated February 25, 2013 and the appeal was assigned to Case No. 13-3003. The individual appeal included eight issues, including the Medicare Fraction Part C Days issue (Audit Adjustments Nos. 4 & 6).

The Medicare Fraction Part C days issue was transferred to the SRI Presence 2007 Medicare Fraction Part C CIRP group, Case No. 14-1397GC, on April 25, 2014.

According to the Audit Adjustment Report submitted in the individual appeal, Adjustment No. 4 was made to adjust the SSI percentage and DSH percentage. However, there was no change between the initial value of 8.02 and the new value as a result of the revised NPR. Adjustment No. 6 was made to update the SSI percentage for Capital DSH in accordance with CMS Ruling 1498-R and, again, there was no change made between the original value and the new value in the revised adjustment report – both of which remained 8.02.

**Board Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

**A. Relevant Regulations – Revised NPRs**

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination

> or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Accordingly, pursuant to 42 C.F.R. § 405.1889(b) (and § 405.1835(a)(1) which references that regulation), the Board has jurisdiction only over those matters that have been "specifically revised" in a revised determination. More specifically, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[1]

Here, the Board finds that it does not have jurisdiction over Our Lady of the Resurrection as a participant in this group. The Provider appealed from a revised NPR but there was no change in the adjustment to the SSI and DSH percentages. Adjustment No. 4 states: "[t]o adjust the SSI % and DSH % to audited amounts in accordance with PRM-2, Section 3630.1, 42 CFR 412.106fff, and 1498-R." The corresponding adjustment was "0.00" for both the SSI percentage and DSH percentage and, as a result, there was no change in value for either the SSI percentage or the DSH percentage.

While the documents included in the transfer request for Our Lady of the Resurrection does not include a copy of the Notice of Reopening that resulted in the revised NPR at issue, the reference to CMS Ruling 1498-R suggests that the revised NPR was issued as a result of a 1498-R remand. However, the fact that CMS Ruling 1498-R may have prompted the reopening and issuance of the revised NPR at issue has no bearing here. The three components, or issues, of the SSI fraction addressed by 1498-R and for which 1498-R "eliminate[d] any actual case or controversy" were:

1. "*[T]he Data Matching Process Used in Calculating the SSI Fraction*." The Ruling applied to then-pending appeals of this issue "challenging CMS's data matching process, which the agency uses in determining the SSI fraction by matching Medicare and SSI eligibility data." The seminal case dealing with this issue is *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008). As a result, this issue is sometimes referred to as the *Baystate* SSI data matching issue.

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[1] 42 C.F.R. § 405.1889(b)(1).

2. "*[T]he Exclusion from the DPP [i.e., disproportionate share percentage] of Non-Covered Inpatient Hospital Days for Patients Entitled to Medicare Part A, and Days for Which the Patient's Part A Inpatient Hospital Benefits were Exhausted*." The Ruling applied to "cost reports with discharges before October 1, 2004" for which hospitals have pending "appeals seeking inclusion in the DPP of inpatient days where the patient was entitled to Medicare Part A but the inpatient hospital stay was not covered under Part A" (e.g., exhausted days and Medicare secondary payor ("MSP") days).

3. "*[T]he Exclusion from the DPP of Labor/Delivery Room ["LDR"] Inpatient Days.*" The Ruling applied to "cost reporting periods beginning before October 1, 2009" for which hospitals have pending appeals "seeking inclusion of LDR inpatient days in the DPP regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour."

The only issues covered by Ruling 1498-R that could be applicable to Our Lady of Resurrection Medical Center for FY 2007 is the Baystate data match process issue or Labor/Delivery Room Days. It does ***not*** include the Part C days issue.[2] As a result, the only manner in which the Board has determined that it has jurisdiction over the Part C days issue *in the context of a revised NPR* is if: (1) the SSI percentage is specifically adjusted for Part C Days; ***or*** (2) a new and different SSI percentage is generated where the Board must necessarily assume that there was a change in the underlying data changed and that the Part C days also changes. Here, the SSI percentage clearly was not adjusted for Part C days and, unless there is evidence to the contrary (which there is not), the Board must presume the underlying Part C days data were not changed since there was no change in the SSI percentage itself.[3] In this regard, the Board notes that the Provider is challenging the regulation promulgated in the August 11, 2004 final rule that requires these Part C days to be counted in the SSI fraction and there is no dispute about the amount or number of Part C days included in the SSI fraction itself.

Accordingly, if Our Lady of Resurrection Medical Center wished to appeal or contest the Part C days issue for FY 2007, it should have appealed that issue from its original NPR when it clearly had the right to do so since appeals of any potential future RNPRs is limited to matters "specifically revised."[4] In this regard, the Board notes that Ruling 1498-R did not apply to SSI

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[2] In other words, a provider could appeal the Part C days issue from their original NPR and CMS Ruling 1498-R did not impact any Part C Days appeals. Here, it appears as if Our Lady of Resurrection Medical Center opted not to appeal the Part C days issue from its original NPR for FY 2007. *See infra* note 3.

[3] The Board is aware of situations in which a provider was subject to a 1498-R remand but, *prior to that remand being effectuated*, the provider received an unrelated reopening and was issued a revised NPR with the new SSI percentage resulting from the new data match process, thereby rendering the later 1498-R effectuation perfunctory with a "0.00" adjustment.

[4] For context, the Board takes administrative notice that:

1. The final rule establishing the Agency's current policy on treatment of Part C days in the SSI fraction (and the one at issue in this case) was issued on August 11, 2004 and the Agency's Part C days policy, both prior to and following the August 11, 2004 final rule, has been subject to much litigation. *See, e.g.*, *Northeast Hosp. Corp. v. Sebelius*, 699. Supp. 2d 81 (D.D.C. 2010), *aff'd by*, 657 F.3d 1 (D.C. Cir. 2011); *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012), *aff'd by*, 746 F.3d 1102 (D.C. Cir. 2014); *King & Spalding*

Medicare Part C days issues and, thus, the SSI Medicare Part C Days issue was outside the scope of Ruling 1498-R.[5] The Board recognizes that Ruling 1498-R states that a revised NPR issued following a 1498-R remand ***of the Baystate SSI data matching issue*** "will be subject to administrative and judicial review in accordance with the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines." However, "the applicable jurisdictional and procedural requirements of . . . the Medicare regulations" includes 42 C.F.R. § 405.1889 and, as discussed above, this regulation limits Board jurisdiction to "those matters that are specifically revised." Here, it is clear that the Part C days issue was both outside the scope of 1498-R and not "specifically" revised in the revised NPR at issue for Our Lady of Resurrection Medical Center.[6]

In summary, because there was no revision to the SSI percentage, the audit adjustment associated with the revised NPR does not meet the requirements of the regulation for Board jurisdiction of matters revised in a revised NPR and the Provider does not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[7] Therefore, the Board dismisses Our Lady of the Resurrection from the group pursuant to 42 C.F.R. § 405.1889. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of this appeal.

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*Inclusion of Medicare Advantage Days in 2007 SSI Ratios v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D38 (June 29, 2010) (This "D-" decision is an EJR determination. The Board does not routinely publish EJR determinations as "D-" decisions and will do so only when the EJR determination is *seminal*.).

2. Most providers filing Board appeals of the Part C days issue have done so by appealing from their original NPR, regardless of whether that NPR was issued prior to or after 1498-R (including certain appeals filed pre-2010 in which the provider later requested bifurcation of the Part C days issue from dual eligible days issues emanating from the same August 11, 2004 final rule).

[5] *See* CMS Ruling 1498-R at 18 (stating: "[I]f the administrative tribunal finds that a given claim is outside the scope of the Ruling (because such claim is not for one of the three DSH issues) or the claim fails to meet the applicable jurisdictional and procedural requirements for relief under the Ruling, then the appeals tribunal will issue a written order, briefly explaining why the tribunal found that such claim is not subject to the Ruling. The appeals tribunal will then process the provider's original appeal of the same claim in accordance with the tribunal's usual, generally applicable appeal procedures.").

[6] Further, the Board notes that, if the issue in this appeal had pertained to the *Baystate* data match process issue (as opposed to the Part C days issue), the situation would be very different and the Board would have jurisdiction over it pursuant to Ruling 1498-R and 42 C.F.R. § 405.1889(b). In that scenario, while the provider's revised NPR would have no adjustment, the provider would be trying to resume its original PRRB appeal of the *Baystate* SSI data match process issue (which the Ruling had eliminated and required the Board to remand) and would be dissatisfied with the intervening application of a new data match process (as mandated by Ruling 1498-R) that did not change to its SSI fraction (*i.e*, it would be dissatisfied with the mandated new data matching process did not result in a change to its SSI fraction due to flaws in that new data matching process).

[7] *See, e.g., St. Mary's of Mich. v. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020)*, Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

The Board will issue a determination regarding the applicability of CMS-1739-R for the remaining participants in the group, Case No. 14-1397GC, under separate cover.

<u>Board Members</u>:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

2/1/2021

X Clayton J. Nix

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

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

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RE: ***Jurisdictional Determination***
El Camino Hospital (05-0308) FYE 06/30/2016, Case No. 20-1990

Dear Ms.Ponce and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Representative's January 28, 2021 requests for transfer of issues in the subject appeal to three optional groups. The pertinent facts and the Board's jurisdictional determination are set forth below.

**Background**

On August 28, 2019, the Provider requested ". . . a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year . . . . for the purpose of recalculating the Hospital's Medicare disproportionate share hospital (DSH) entitlement."

The Medicare Contractor issued a Notice of Amount of Corrected Program Reimbursement[1] (Revised NPR ("RNPR")) on February 27, 2020. The audit adjustment report accompanying the RNPR indicates that adjustment #4 was made "[t]o adjust SSI Percentage and Disproportionate Share Amount based on the latest CMS Letter of SSI Percentage Realignment."

Toyon Associates, Inc. ("Toyon") filed an individual appeal of the RNPR with the Board on August 19, 2020. The appeal included three issues:

1. DSH Accuracy of CMS Developed SSI Ratio ("SSI Accuracy")
2. DSH Inclusion of Medicare Part C Days in the SSI Ratio ("SSI Fr. Part C Days")
3. DSH Inclusion of Medicare Part A Unpaid in SSI Ratio ("SSI Fr. Part A Days")

[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").

On January 28, 2021, Toyon requested the transfer of the three issues in the individual appeal to the following optional groups:

| ***Case No.*** | ***Group*** |
|---|---|
| 21-0647G | Toyon CY 2016 Accuracy of CMS Developed SSI Ratio #2 Group |
| 21-0648G | Toyon CY 2016 Medicare Part C Days-SSI Ratio/DE Part C Days-Medicaid Ratio Group |
| 20-1845G | Toyon CY 2016 Inclusion of Medicare Part A Unpaid Days in SSI Ratio Group |

On the same date, Toyon requested the closure of the individual case as there were no remaining issues.

**Board Determination**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

**Relevant Regulations – RNPRs**

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018)[2] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834,

[2] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

> 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

The Board finds that it does not have jurisdiction over the SSI Accuracy, SSI Fr. Part C Days and SSI Fr. Part A Days issues in this individual appeal, which was filed from a RNPR.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. The audit adjustment (#4) associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[4] Since the only matters specifically revised in the RNPR was an adjustment related to the realigned SSI percentage, the Board does not have jurisdiction over the three issues in the subject individual appeal.

Further, as a result of the dismissal, the Board denies the Provider's transfer requests to Case Nos. 21-0647G, 21-0648G and 20-1845G. Moreover, ***the Board admonishes Toyon for these transfer requests*** because had the Board approved the transfer requests they would have perpetuated **duplicate 2016** appeals of the same underlying issues in violation of Board Rules and regulations, as well as basic civil procedure. As previously noted, the issues being

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[3] 42 C.F.R. § 405.1889(b)(1).

[4] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

transferred to Case Nos. 21-0647G, 21-0648G and 20-1845G were for SSI Accuracy, SSI Fr. Part C Days and SSI Fr. Part A Days issues for 2016. However, El Camino Hospital already had appealed those same issues for 2016 from an earlier determination and had those issues are pending *in other **Toyon** 2016 optional groups* as follows:

1. Case No. 19-2381G entitled "Toyon Associates CY 2016 Accuracy of CMS Developed SSI Ratio Group"
2. Case No. 19-2380G entitled "Toyon Associates CY 2016 DSH Medicare Part C - SSI Ratio/DE Part C - Medicaid Ratio Group";
3. Case No. 19-2379G entitled "Toyon Associates CY 2016 DSH Medicare Part A - SSI Ratio/DE Part A - Medicaid Ratio Group."[5]

Board Rules prohibit duplicate cases in Board Rule 4.6 entitled "No Duplicate Filings." In particular, Board Rule 4.6.2 states:

> Same Issue from Multiple Determinations Appeals of the same issue from distinct determinations ***must be pursued in a single appeal***. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals.

To this end, Board Rule 6.4 entitled "Certifications" require Representatives to make the following certification when they file an appeal with the Board:

> The person filing the appeal request on behalf of a provider must certify the submission, specifically:
>
> - I certify that ***none of the issues filed in this appeal*** *are pending* in any other appeal for the same period and provider, *nor have they been adjudicated, withdrawn, or dismissed* from any other PRRB appeal.[6]

As a result, *to the extent El Camino desires to appeal the **same** issue for **same** fiscal year but from different determinations*, ***then Toyon needs to ensure that those appeals are either directly added to the relevant existing case or consolidated and pursued in only a single case*** (whether as part of a group or in an individual case). As such, the transfer request has they been valid in the first instance should have been to Case Nos. 19-2381G, 19-2380G, and Case No. 19-2379G where El Camino already was pursuing those same 2016 issues (as opposed to Case Nos. 21-

[5] The Board has not reviewed the group issue statements for any of the groups. However, Case Nos. 19-2381G, 19-2380G, and Case No. 19-2379G appear to be the same as or, at a minimum, fully encompass the stated group issues in Case Nos. 21-0647G, 21-0648G and 20-1845G.
[6] (Emphasis added.)

0647G, 21-0648G and 20-1845G). ***The Board takes administrative notice that this same issue has arisen in other Toyon group appeals and, as a result, it recently directed Toyon to review its current inventory of all group cases pending with the Board to identify and remove any duplicate group cases (whether through requests for consolidation or withdrawal).*** *If Toyon does not take steps to identify and remove duplicate cases and if it continues to make improper or inaccurate filings, the Board may consider taking additional remedial actions as authorized by 42 C.F.R. § 405.1868(b), including but not limited to, sending direct notice to the impacted underlying provider(s).*

* * * * *

In conclusion, the Board dismisses the SSI Accuracy, SSI Fr. Part C Days and SSI Fr. Part A Days issues from Case No. 20-1990 as the Provider does not have the right to appeal the RNPR at issue under 42 C.F.R. § 405.1889. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[7] As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 20-1990 and removes it from the Board's docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

2/4/2021

X Clayton J. Nix

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

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

[7] *See, e.g., St. Mary's of Mich. v. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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February 10, 2021

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RE: Board Determination on Reinstatement of Individual Appeal
Evangelical Community Hospital
Provider Number: 39-0013
Appealed Period: FYE 06/30/2015
PRRB Case Number: 18-0366

Dear Ms. O'Brien Griffin and Mr. Snyder:

On December 31, 2020, the Provider Reimbursement Review Board (the "Board") closed the subject case, in response to Hall, Render, Killian, Heath and Lyman's (Hall Render's) request to withdraw three issues. On the same date, Hall Render filed a request for reinstatement of the case. In its reinstatement request, Hall Render claimed that, after the withdrawal of issues, the DSH Medicare Fraction - SSI Percentage issue still remained pending in the appeal. The Board disagrees. Upon review, the Board notes that, in the Provider's preliminary position paper filed on September 4, 2018, Hall Render only briefed only two issues. Pursuant to Board Rule 25.3, "[a]ny issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn." As the DSH Medicare Fraction - SSI Percentage was not one of the two issues briefed in the preliminary position paper, it was no longer pending in the case. Therefore, the Board finds the closure of the case based on the December 31, 2020 withdrawal of issues to have been proper and the case remains closed.

<u>Board Members Participating:</u>
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

Clayton J. Nix, Esq.
Chair

cc: Wilson C. Leong, Federal Specialized Services

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

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Nashville, TN 37202

Re: ***Jurisdictional Determination***
UC Health CY 2008 DSH Post 1498R Medicare Part A/SSI% CIRP Group
Case No. 20-0608GC

Dear Mr. Newell and Ms. Cummings:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned common issue related party ("CIRP") group case for University of Cincinnati Health ("UC Health"), in response to the Group Representative's notice of group completion. Set forth below are the pertinent facts and the Board's determination.

**Pertinent Facts:**

The UC Health CY 2008 DSH Post 1498R Medicare Part A/SSI% CIRP Group was filed by Southwest Consulting Associates ("SCA"/"Representative") on January 13, 2020. The group was formed with University of Cincinnati Medical Center, LLC (36-0003), which filed from a revised Notice of Program Reimbursement ("NPR") issued on July 24, 2019.

According to the Notice of Reopening submitted, the cost report for University of Cincinnati Medical Center was reopened "[t]o update the SSI% based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received June 17, 2015."

The Provider identified audit adjustments 1 and 3 – both of which updated ". . . the SSI% and DSH payment factor in accordance with CMS'SSI realignment calculation."

On January 11, 2021, SCA advised that the group was fully formed.

On January 26, 2021, in accordance with Board Rule 22, the Medicare Contractor ("MAC") reviewed the final Schedule of Providers and jurisdictional documentation for the group. In its review letter, the MAC indicates that the case is not suitable for a group because it includes only a single participant and, therefore, does not meet the requirement in Board Rule 12.6.1 which requires at least two different providers upon full formation.

**Board's Decision:**

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

**Relevant Regulations – RNPRs**

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018)[1] explains the effect of a cost report revision:

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

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[1] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020)*, Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

The Board finds that it does not have jurisdiction over the subject case. First the Board finds that it lacks jurisdiction over the DSH Post 1498R Medicare Part A/SSI% issue for the University of Cincinnati Medical Center, LLC because the revised NPR from which it filed was issued as a result of the Provider's SSI Realignment request, and did not adjust the Medicare Part A/SSI % issue which is under appeal in this group.

42 C.F.R. § 405.1889(b)(1) specifies that, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are *specifically* revised[.]"[2] The reopening for University of Cincinnati Medical Center, LLC was issued as a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to the individual cost reporting fiscal year end. Further, the audit adjustments associated with the revised NPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. In other words, the determination was only being reopened to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the provider's fiscal year and the realignment process does not change any of the underlying data.[3] Since the only matter specifically revised in the revised NPR were adjustments related to the realigned SSI percentage, the Board does not have jurisdiction over University of Cincinnati Medical Center, LLC.

Lastly, the Board lacks jurisdiction over the subject group pursuant to 42 C.F.R. § 405.1837(b)(1) and Board Rule 12.6.1 which indicate that a single provider under common ownership or control may *initiate* a CIRP group, but at least two different providers must be in the group ***upon full formation***. Here, Representative certified that the group was fully formed on January 11, 2021 with one participant.

Therefore, the Board dismisses the single participant, University of Cincinnati Medical Center, LLC, from the appeal as it does not have the right to appeal the revised NPR at issue under 42 C.F.R. § 405.1889. As there are no other participants in the group, the

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[2] (Emphasis added.)

[3] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

Board hereby dismisses Case No. 20-0608GC and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

2/10/2021

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**

Good Shepherd Health System
Brandon Amyx
700 E. Marshall Avenue
Longview, TX 75604

Novitas Solutions, Inc.
Justin Lattimore
Director, JH Provider Audit & Reimbursement
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: ***Jurisdictional Determination***
Good Shepherd Medical Center
FYE 9/30/06
Case No. 17-0370

Dear Messrs. Amyx and Lattimore,

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

**Background**

The Provider submitted a request for hearing on October 28, 2016, based on a Revised Notice of Program Reimbursement ("RNPR") dated May 4, 2016. The Provider appealed the outlier recoupment of $600,047, including $491,345 of outlier payments and $108,702 for the time value of money (interest). The Provider describes the issue as follows:

> The statutory basis for the outlier reconciliation is a rule issued in 2003 entitled "Change in Methodology for Determining Payment for Extraordinary High-Cost Cases (Cost Outliers) Under Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems, 68 Fed. Reg. 34,494 (June 9, 2003). At that time CMS indicated intent to issue implementation guidelines for the rule "in the near future." However, issuance of the guidelines were delayed and finally issued in December 2010 – over seven years after the 2003 rule took effect.
>
> The provider asserts that the Medicare Contractor and CMS lacks the statutory and regulatory authority to require the provider to repay the outlier payments, plus imputed interest. We contend that the regulation that authorizes the reconciliation process ("the 2003 rule" and the guidelines that implement that rule ("the 2010 guidelines" or "the 2010 manual") were improperly promulgated

> and are contrary to the terms of the Medicare statute. Likewise, the CMS decision to recoup the $491,345 of outlier payments and impute interest $108,702 of interest was improper. CMS procedures were procedurally defective because the agency failed to employ required notice-and-comment procedures prior to adopting the guidelines.[1]

**Discussion and Analysis**

As part of the Balanced Budget Act of 1997, Congress promulgated 42 U.S.C. § 1395ww(j) to create the IRF-PPS for cost reporting periods beginning on or after October 1, 2002.[2] Section 1886(j) of the Act authorized the implementation of a per-discharge PPS for inpatient rehabilitation hospitals and rehabilitation units of acute care hospitals, collectively known as IRFs. As required by Section 1886(j) of the Act, the Federal rates reflect all costs of furnishing IRF services. With respect to the "prospective payment rates", section 1886(j)(3) of the Act states:

> (3) *Payment rate.*-
> (A) *In general*.- The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted-
> (i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;
> (ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payments amounts which are additional payments described in paragraph (4) (relating to outlier and related payments);
> (iii) for variations among rehabilitation facilities by area under paragraph (6);

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[1] The Medicare Contractor also challenged three additional LIP issues but the Provider subsequently withdrew them from the appeal.
[2] Pub. L. No. 105-33, 111 Stat. 251 (1997).

> (iv) by the weighting factors established under paragraph (2)(B); and
> (v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

In creating new paragraph (j), Congress also specified that there was a limitation on administrative and judicial review with respect to the IRF PPS payment rates. Specifically, section 1886(j)(8) of the Act provides:

> (8) Limitation on review.- There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of-
> (A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),
> (B) the prospective payment rates under paragraph (3),
> (C) outlier and special payments under paragraph (4), and
> (D) area wage adjustments under paragraph (6)

With regard to the limitation on review, the regulation at 42 C.F.R. 412.630 reads as follows:

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

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates 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 2018 decision of the U.S. Court of Appeals, District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*"),[3] sets out its analysis of this issue when it answers this question and clarifies what is shielded from review.

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." 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. In *Mercy*, the D.C. Circuit affirmed the District Court's decision to dismiss, for lack of subject-matter jurisdiction, Mercy Hospital's challenge to the Medicare Contractor's calculation of Mercy

[3] 891 F.3d 1062 (June 8, 2018)

Hospital's LIP adjustment for the fiscal years under appeal. In explaining its reasoning behind upholding the dismissal, the D.C. Circuit concludes 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.[4]

**Board Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Medicare statute at 42 U.S.C. § 1395ww(j) directs CMS to set Medicare rates for inpatient rehabilitation services through a two-step process. The first step involves establishing a standardized reimbursement rate for each discharges patient based on the average estimated cost of inpatient operating facilities and treating patients for the upcoming year. The second step takes place after the fiscal year has ended, when CMS adjusts the standardized rates to reflect the particular circumstances of each hospital for that year. These adjustments authorized in the statute include four specific adjustments for price increases in the relevant market, outlier adjustments, wage index adjustments and case mix adjustments.

The D.C. Circuit in *Mercy* ruled that subsection (8) expressly shields from administrative and judicial review "prospective payment rates" and most statutory adjustments used to calculate them under the inpatient rehabilitation formula. The D.C. Circuit rejected the hospital's limited reading of the language "prospective payment rates" as including only the unadjusted rates at step one of the formula, that is the standardized payment rates. The D.C. Circuit concluded that the statute defines "prospective payment rate" as the amount that is determined after the fiscal year ends, when CMS, as the second step of the payment process, adjusts the standardized rates to reflect the particular circumstances of each hospital for that year. The D.C. Circuit ruled that both as a textual and practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and thus that the preclusion provision applies to the LIP adjustment just as it applies to the other adjustments described in paragraph (8).

In the instant appeal, Good Shepherd Medical Center seeks Board review of one of the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and calculating Good Shepherd's final payment. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the outlier payment adjustment, the Board lacks the jurisdiction to hear Good Shepherd's appeal. The Board also lacks jurisdiction over whether the regulation authorizing the reconciliation process was improperly promulgated and contrary to the terms of the Medicare statute. As such, the Board dismisses the appeal and removes it from the Board's docket. In making this finding, the Board

[4] *Mercy*, 891 F.3d at 1068

notes that the D.C. Circuit's decision in *Mercy* is controlling precedent for the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[5]

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

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

2/10/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

[5] 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**

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**Via Electronic Delivery**

Glenn Bunting
Moss Adams LLP
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Rancho Cordova, CA 95670

RE: ***EJR Determination***
Renown Regional Medical Center (Prov. No. 29-0001)
FYEs 6/30/2008, 6/30/2010, 6/30/2011
Case Nos. 13-2320, 14-1805, 14-3448

Dear Mr. Bunting:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced three individual appeals for Renown Regional Medical Center ("Provider") incident to the Board's Own Motion EJR Request for Comment issued December 16, 2020 ("Board's Request for Comment"). The Board's Request for Comment provided notice to the parties that the Board was considering issuing a decision on its own motion to grant expedited judicial review ("EJR") on the Provider's *sole remaining* issue concerning the Centers for Medicare & Medicaid Services' ("CMS") treatment in the Disproportionate Patient Percentage ("DPP") of non-covered Medicare Part A days for dual-eligible patients.[1]

The Board has reviewed the record in the above-referenced appeals, and determined it has jurisdiction over the Provider's appeals, but lacks the authority to grant the relief sought the *sole remaining* issue in these appeals. The Board's rational is set forth below.

**Issue under Appeal**

The issue under appeal in these cases is:

> Renown's challenge concerns the FFY 2005 Inpatient Prospective Payment System (IPPS) Final Rule's (i.e. 2005 Rule) interpretation of the statutory phrase "entitled to [Medicare]" in its implementing regulation, 42 C.F.R. § 412.106(b)(2)(i), and that interpretation's effect on the treatment of "dual eligible exhausted coverage patient days." These are patient days attributable to patients eligible for both Medicare and Medicaid and whose hospital stays have exceeded the

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[1] *See* 42 C.F.R. § 405.1842(c). The non-covered days included days for which Medicare was a secondary payer, days where the individual had exhausted his or her Medicare Part A benefits, and days in stays denied under Medicare for medical necessity or technical reasons.

> 90-day limit applicable to Medicare coverage (after which Medicare ceases to cover the patient's inpatient hospital services costs).[2]

**Statutory and Regulatory Background**

***A. Adjustment for Medicare DSH***

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

The statutory provisions governing IPPS contain 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 IPPS 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]

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[2] Provider's Final Position Paper at 3.
[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.)

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

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

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

### *B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation*

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[14] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[15]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[16] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[17] The Secretary then summarized its policy by stating that "our

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[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[15] *Id.*
[16] *Id.*
[17] *Id.*

current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[18]

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[19] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[20] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[21]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[22] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[23] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [24] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[25]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[26] Rather, he

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[18] *Id.* at 27207-27208.
[19] *Id.* at 27207-08.
[20] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[21] 68 Fed. Reg. at 27208.
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).

stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[27]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[28]

In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[29]
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> ****
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> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* **in the Medicare fraction** *of the DSH calculation.*[30]

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[27] *Id.*
[28] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[29] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[30] *Id.* at 49099 (emphasis added).

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[31] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[32] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (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* ***covered*** *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 and SSI, excluding those patients who received only State supplementation . . .[33]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now 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 and SSI, excluding those patients who received only State supplementation . . .[34]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[35]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[36] the

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[31] *Id.*
[32] *See id.* at 49099, 49246.
[33] (Emphasis added.)
[34] (Emphasis added.)
[35] *Id.*
[36] 317 F. Supp. 3d 168 (D.D.C. 2018).

U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[37] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[38] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[39] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[40] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[41] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[42] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[43]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[44] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[45] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[46] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate contest in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[47] and that the regulation is procedurally invalid.[48]

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[37] *Id.* at 172.
[38] *Id.* at 190.
[39] *Id.* at 194.
[40] *See* 2019 WL 668282.
[41] 718 F.3d 914 (2013).
[42] 657 F.3d 1 (D.C. Cir. 2011).
[43] 718 F.3d at 920.
[44] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[45] *Id.* at 1141.
[46] *Id.*
[47] *Id. at 1162.*
[48] *Id. at 1163*

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[49] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[50] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[51] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[52] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[53] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[54] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[55] Accordingly, the Ninth Circuit to the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force).

As of the date of this decision, the Secretary's position with respect to the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

**<u>FSS' Response to the Board's request for comments regarding own-motion EJR</u>**

FSS states that it is clear that the Provider is challenging the validity of CMS' treatment in the Disproportionate Patient Percentage of non-covered Medicare Part A days for dual eligible patients. Because the Board is bound by the very CMS regulation that the Provider is challenging, the Medicare Contractor asserts the Board is without the authority to decide the legal question raised in this appeal and therefore considers the granting of EJR to be proper.

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[49] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir., Oct. 20, 2020). It is unclear if the Secretary will petition the U.S. Supreme Court to review the Ninth Circuit's *Empire* decision.
[50] *Id.* at 884.
[51] *Id.* at 884.
[52] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[53] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[54] *Id.* at 886.
[55] *Id.*

**<u>Provider's Response to the Board's request for comments regarding own-motion EJR</u>**

The Provider did not timely respond to the Board's request for comments and, as of the date of this decision, still has not responded.

**<u>Decision of the Board</u>**

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.

While the Provider did not respond to the Board's Request for Comment, the Provider's Final Position Paper clearly lays out its position on the sole remaining issue in this appeal. The Provider contends the Medicare Contractor's adjustment to utilize an incorrectly calculated SSI ratio in the Provider's Medicare DSH payment calculation has resulted in an understatement of Medicare DSH payment. Specifically, the Provider challenges the Medicare Contractor's and CMS' decision to calculate and utilize a SSI ratio that contains Medicare non-covered no-pay Part A days in this cost reporting year when it had been CMS' *past* practice to not include Medicare non-covered Part A days in the SSI ratio. In short CMS' change in the FFY 2005 IPPS Final Rule Rule is a substantive modification that is inconsistent with the *Chevron* framework and judicial precedent from past decisions impacting this issue.[56]

The Provider is located in the Ninth Circuit and maintains that its position is consistent with the U.S. Court of Appeals for the Ninth Circuit decision in *Empire Health Foundation v. Azar* issued on May 5, 2020.[57] The Provider contends CMS substantively violated the FFY 2005 IPPS 2005 Rule and, in essence, is seeking to apply the Ninth Circuit's decision in *Empire* to its appeals.[58] However, the Secretary has not yet acquiesced to the *Empire* decision.
Accordingly, based upon the *Empire* decision, the Provider requests CMS recalculate the Provider's SSI ratio *excluding* all Medicare non-covered Part A days, thereby reverting back to the pre-FFY 2005 IPPS Final Rule policy to use Utilization Days (*i.e.*, Medicare Part A paid days) in the denominator of the SSI ratio calculation.[59]

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[56] Provider's Final Position Paper at 5.
[57] The Board notes that the Provider is located in the Ninth Circuit Court of Appeals.
[58] Provider's Final Position Paper at 5.
[59] Provider's Final Position Paper at 9.

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and the Provider is entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i) 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) codifying the Medicare dual eligible days policy adopted in the FY 2005 IPPS final rule is substantively valid and to provide the requested relief that "CMS recalculate the Provider's SSI ratio excluding all Medicare non-covered Part A days, thereby reverting back to the pre 2005 Rule Use of Utilization Days (i.e., Medicare Part A paid days) in the denominator of the SSI ratio calculation, as set forth in CMS' MedPar data file."[60]

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (2005) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants EJR for the issue and the subject years as stated above. 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 these cases, the Board hereby closes the cases.

Board Members Participating:

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Robert A. Evarts, Esq.
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For the Board:

2/11/2021

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions
Wilson Leong, FSS

[60] *Id*. The Provider asserts that removing Medicare non-covered Part A days would increase the Provider's SSI ratio from 9.20 percent to 9.66 percent resulting in a net increase in the Provider's DSH payment of $170,392. *Id.*

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

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**Via Electronic Delivery**

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RE: **Jurisdictional Determination**
18-1771G – King & Spalding CY 2015 Low Income Pool § 1115 Rehab DSH Waiver Days Grp
19-2097G – King & Spalding CY 2016 Low Income Pool § 1115 Rehab DSH Waiver Days Grp

Dear Mr. Polston and Mr. Pike:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the 2018 decision of U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") Section 1115 Waiver Days issue in these group appeals and dismisses the instant appeals.

**Pertinent Facts**

The Requests for Hearing ("RFHs") in the above group appeals included the following issue statements:

> The Providers are appealing the Intermediary's exclusion of days associated with the Section 1115 Rehab Medicare Florida Low-income Pool ("LIP") waiver from the numerator of the Medicaid fraction of the Medicare DSH payment for Inpatient rehabilitation distinct-part unit ("IRFs") Sec. 1115 waiver be included in the DSH calculation.[2]

On January 23, 2020, the MAC filed a jurisdictional challenge, contending that the Board does not have jurisdiction over the IRF LIP payment or any of its components, and moves to dismiss these group cases under the findings of *Mercy*. On February 3, 2020, the Provider responded to the challenge.

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).
[2] Providers' Request for Hearing, Group Issue Statement (Aug. 29, 2018), PRRB Case no. 18-1771G.

**MAC's Position**

The Inpatient Rehab Facility ("IRF") low income patient ("LIP") adjustment is a component of the IRF prospective payment rate established under § 1886(j)(3)(A)(v) of the Social Security Act ("SSA"). The MAC argues that in accordance with § 1886(j)(8)(B), there is no administrative or judicial review of the IRF prospective payment rates under paragraph (3). Because the IRF LIP payment has been established under paragraph (3), the contractor contends that the Board does not have subject matter jurisdiction over the IRF LIP payment or any of its components.[3]

In responding to comments made in response to the Secretary's final rule in the Federal Register regarding IRF LIP adjustments, the Secretary specifically noted that the LIP adjustment was an adjustment under § 1886(j)(3)(A)(v).[4] Because the LIP adjustment is a component of the IRF prospective payment rate established under § 1886(j)(3), administrative and judicial review of the LIP adjustment are statutorily precluded by § 1886(j)(8).

42 C.F.R. § 405.1867 mandates that the Board comply with all of the provisions of the Medicare Act and the regulations issued thereunder. Accordingly, SSA § 1886 (j)(8)(B) precludes administrative review of the IRF LIP adjustment, and thereby divests the Board of jurisdiction to hear these issues in the Provider's appeal.[5]

Further, the MAC argues that the U.S. District Court for D.C. upheld the Administrator's decision in *Mercy* holding that "the plain language of the statute precludes review of the contractor's determination."[6] Following appeal, on June 8, 2018, the D.C. Circuit affirmed the District Court's decision.

Finally, in the recent review of a jurisdictional challenge in Case No. 13-0805 to the administrative and judicial review of the IRF PPS rates established under 42 U.S.C. § 1395ww(j)(3)(A), the Board concluded that it does not have jurisdiction over the LIP issue because the D.C. Circuit held in *Mercy* 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."[7]

Therefore, consistent with *Mercy* and the Board's recent jurisdictional decision in Case No. 13-0805, the MAC respectfully requests that the Board dismiss the IRF LIP issue for lack of subject matter jurisdiction pursuant to 42 C.F.R. § 412.630.

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[3] MAC's Jurisdictional Challenge, at 1 (Jan. 23, 2020).
[4] *Id.* at 3. *See also* 66 Fed. Reg. 41316, 41361 (Aug. 7, 2001).
[5] *Id*.
[6] *Id*. at 4.
[7] *Id*.

**Providers' Position**

The Providers argue that the IRFs at issue, all timely appealed the MAC's issuance of their respective notices of program reimbursement ("NPRs") within 180 days of receipt. The Providers maintain that, as discussed below, they have met all of the requirements for the Board to maintain jurisdiction under 42 U.S.C. §§ 1395oo(a) and 42 C.F.R. § 405.1835. Nonetheless, the MAC has challenged the Board's jurisdiction by letter dated January 23, 2020, contending that "the Board does not have subject matter jurisdiction over the IRF LIP payments or any of its components" under 1886(j)(8)(B) of the Social Security Act. The Providers contend that the MAC reads this provision too broadly, and that the Board should reject the MAC's challenge. The statute precludes judicial and administrative review only of the weights and other inputs that determine unadjusted IRF PPS rates and not adjustments adopted by the Secretary through her authority to adjust payment rates "necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities," such as the IRF DSH adjustment. Accordingly, the Providers maintain that the Board has jurisdiction over this appeal and should decide it on the merits.[8]

The Providers argue that they meet the statutory requirements for a Board hearing, that the IRF PPS Statute Does Not Preclude Review of the IRF DSH Adjustment, and that CMS's subsequent attempts to limit Board jurisdiction over the IRF DSH adjustment are invalid as they directly conflict with the statutory provisions that permit review of the IRF DSH adjustment. Significantly, the Providers do not respond to the holdings in the *Mercy* cases.

**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.

[8] Providers' Jurisdictional Response, at 1 (Feb. 3, 2020).

**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.[9]

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."[10] 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.[11] 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.[12]

In the instant appeals, 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. 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 appeals that challenge this adjustment. In making this finding, the Board notes that the D.C. Circuit's decision in *Mercy* is controlling precedent on the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[13]

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[9] *Id.*
[10] *Id.* at 1064.
[11] *Mercy Hosp., Inc. v. Burwell,* 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[12] *Mercy*, 891 F.3d at 1068.
[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).

Accordingly, the Board hereby dismisses Case Nos. 18-1771G and 19-2097G for lack of jurisdiction pursuant to 42 U.S.C. § 1395ww(j)(8)(B) and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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For the Board:

2/11/2021

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Chair
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cc: Edward Lau, Esq., Federal Specialized Services
Wilson Leong, Federal Specialized Services

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**Via Electronic Delivery**

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RE: ***Request for Rescission of Remand Order***
Edward W. Sparrow Hospital (23-0230)
PRRB Case No. 17-0307

Dear Mr. Marcus:

The Provider Reimbursement Review Board ("Board") is in receipt of your letter dated January 22, 2021, in which you request that the Board rescind its Remand Order in the above-captioned case.[1] As explained below, the Board will not rescind its Remand Order issued pursuant to CMS Ruling CMS-1739-R ("Ruling 1739-R" or the "Ruling").

Ruling 1739-R is the response of the Centers for Medicare and Medicaid Services ("CMS") to the United States Supreme Court's decision in *Allina*.[2] The *Allina* decision requires CMS to engage in notice-and-comment rulemaking before adopting a policy of including Medicare beneficiaries enrolled in Medicare Part C[3] in the Supplemental Security Income ("SSI") fraction for purposes of calculating a hospital's disproportionate patient percentage for cost years when there was no governing regulation in place.[4] In Ruling 1739-R, CMS has announced that it will conduct the notice-and-comment rulemaking required by *Allina*.

Additionally, Ruling 1739-R provides notice that the Board lacks jurisdiction over provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the SSI and Medicaid fractions of the disproportionate patient percentage ("Part C Days"). Ruling 1739-R applies only to those appeals regarding Part C Days with discharge dates before October 1, 2013, that arise from Notices of Program Reimbursement ("NPRs") issued before CMS issues a new final rule to govern the treatment of such days or that arise from an appeal based on an untimely NPR and a subsequently issued NPR that pre-dates the new final rule.

Ruling 1739-R directs the Board to remand all jurisdictionally proper Part C Days appeals to the appropriate Medicare contractor, who will calculate the disproportionate share hospital ("DSH")

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[1] Although the case number was incorrectly referenced in the Request for Rescission as 17-0737, the correct case number is 17-0307 and this letter is limited to case number 17-0307.
[2] *Azar v. Allina Health Services,* 138 S.Ct. 1804 (June 3, 2019) (hereinafter "*Allina*").
[3] Also known as "Medicare Advantage."
[4] See *Allina.*

payment adjustment in accordance with a forthcoming final rule. In compliance with Ruling 1739-R, the Board remanded Case No. 17-0737 to the Medicare contractor on January 20, 2021. On January 22, 2021, the Board received your request to rescind the remand order issued in this case. Your request asserts that the remand order was in conflict with the January 20, 2021 White House Memorandum ("WH Memo") imposing a regulatory freeze. For the reasons explained below, the Board disagrees with your assertion and will not rescind its January 20, 2021 remand order.

CMS Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous provisions of the law or regulations relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, private health insurance, and related matters.[5] The Board is required to "comply" with CMS Rulings pursuant to 42 C.F.R. § 405.1867. Accordingly, unless the WH Memo specifically applies to and freezes any further action pursuant to Ruling 1739-R, the Board is bound by the Ruling.

Subject to exceptions for emergent situations identified by the Office of Management and Budget ("OMB") Director, the WH Memo directs agencies and heads of executive departments as follows:

1) no agencies propose or issue any new rules until the President's appointee can review and approve them;
2) immediately withdraw rules that have been sent to, but not published in, the Federal Register;
3) consider postponing the effective dates of rules that have been published, but have not yet taken effect, for 60 days from January 20, 2021;
4) exclude rules subject to statutory or judicial deadlines from these restrictions;
5) acting agency heads should notify the OMB Director of any rules they feel should be excluded from these restrictions for good cause; and,
6) comply with any applicable Executive Orders regarding regulatory management.[6]

The WH Memo also directs that the OMB Director will implement these requirements and that any communications regarding any matters pertaining to this review be addressed to the OMB Director.[7]

As used in the WH Memo, "Rule" means, "the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or

[5] 42 C.F.R. § 401.108; https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings, last accessed February 11, 2021.
[6] https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/regulatory-freeze-pending-review/ last accessed February 11, 2021.
[7] *Id.*

policy or describing the organization, procedure, or practice requirements of an agency. . . ."[8] "Rule" also includes "any substantive action by an agency (normally published in the Federal Register) that promulgates or is expected to lead to the promulgation of a final rule or regulation, including notices of inquiry, advance notices of proposed rulemaking, and notices of proposed rulemaking."[9] Lastly, within its definition, the WH memo includes an "agency statement of general applicability and future effect, other than a regulatory action, that sets forth a policy on a statutory, regulatory, or technical issue or an interpretation of a statutory or regulatory issue."[10]

The Board finds that the WH Memo does not apply to Ruling 1739-R or the Board's remand order, for several reasons. First, Ruling 1739-R is not a "Rule" as defined in the WH Memo. Ruling 1739-R itself will not lead to a final rule or regulation, nor is it a statement of general applicability that sets forth a policy. Ruling 1739-R simply clears the Board's docket of the applicable Part C Days appeals until the time that the Part C Days final rule is properly enacted, at which point the Medicare contractors will compute the providers' DSH payments in compliance with that final rule.[11]

Second, the WH Memo specifically addresses rules that have *not yet* been published or that have been published have but *not yet* taken effect. Although not a rule, the Ruling was both published and became effective on August 17, 2020,[12] well before January 20, 2021. Accordingly, the WH Memo is inapplicable to Ruling 1739-R.

Third, the WH Memo directs that "any communications regarding any matters pertaining to this review should be addressed to the OMB Director."[13] This suggests that the Provider's Representative should be addressing its request to expand the scope of the WH Memo to include Ruling 1739-R to the OMB Director.

Finally, the WH Memo is a directive issued by the Executive Branch to the Executive Agencies and does not create a private right of action. Therefore, the Provider's Representative has no standing to challenge or request the reversal of the Board's January 20, 2021 Remand Order pursuant to the SH Memo.

For all these reasons, the Board finds that the WH Memo does not mandate the remedy requested by the Provider's Representative, and thus, the Board will not rescind its January 20, 2021 Remand Order.

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[8] WH Memo at 3 citing to 5 U.S.C.A. § 551(4).
[9] WH Memo at 3; Executive Order 12866 of September 30, 1993 – Regulatory Planning and Review, § 3(e).
[10] WH Memo at 3; Executive Order 13422 of January 18, 2007 - § 3(g).
[11] Ruling 1739-R at 2.
[12] Ruling 1739-R at 10 specifically states: "This Ruling is effective August 17, 2020."
[13] WH Memo at 3.

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

2/12/2021

X Robert A. Evarts, Esq.

Robert A. Evarts, Esq.
Board Member
Signed by: Robert A. Evarts -A

cc: Byron Lamprecht, WPS Government Health Administrators (J-8)
Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Nathan Summar
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WPS Government Health Administrators
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Re: ***Board Decision on MAC Motion to Dismiss***
Multicare Deaconess Hospital (Prov. No. 50-0044)
FYE 9/30/2015
PRRB Case No. 19-1833

Dear Messrs. Summar and Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed WPS Government Health Administrator's ("WPS") Motion to Dismiss Appeal. The Board's decision is set forth below.

## I. Background

On March 20, 2019, the Board received Provider's appeal of its September 28, 2018, Notice of Program Reimbursement for the Medicare cost reporting period ending on September 30, 2015 ("FY 2015"). Within its Request for Hearing, Provider raised the following five issues:

> Issue 1: DSH – SSI Percentage (Provider Specific) – The Provider contends that its SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation;
>
> Issue 2: DSH – SSI Percentage – Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)?[1]
>
> Issue 3: DSH – Medicaid Eligible Days – Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ('DSH') calculation?

[1] *See* MAC's Jurisdictional Challenge, at 2 (Aug. 7, 2019) (The MAC claims that the Provider raises a dispute over the low-income patient ("LIP") payment within its appeal request for Issue 2. The MAC contends that this is in error as the Provider does not have an Inpatient Rehabilitation Facility ("IRF").).

> Issue 4: Uncompensated Care Distribution Pool – The issue in this appeal involves CMS's calculations of the pool of uncompensated care ("UCC") payments available for distribution to Disproportionate Share Hospital ("DSH") eligible hospitals (i.e., the UCC Distribution Pool issue) as finalized in the 2014 inpatient Prospective Payment System rulemaking on August 02, 2013.
>
> Issue 5: Two Midnight Census IPPS Payment Reduction – Whether the provision in the Fiscal Year 2014 Inpatient Prospective Payment System ("IPPS") Final Rule ("Final Rule") that imposes a .2 percent decrease in the IPPS rates for all IPPS hospitals for each of FYs 2014 -2018 is procedurally invalid, arbitrary and capricious, and outside the statutory authority of the Centers for Medicare & Medicaid Services ("CMS").[2]

On October 22, 2019, the Provider transferred Issues 2, 4, and 5, to required CIRP groups. Accordingly, following those transfers, Issues 1 and 3 (the SSI Provider Specific and Medicaid Eligible Days issues) were the sole remaining issues in the case.

On August 7, 2019, WPS filed a jurisdictional challenge and Issue 1 (the SSI Provider Specific issue) was the only remaining issue implicated in the jurisdictional challenge. On September 4, 2019, the Provider filed a response to WPS' jurisdictional challenge.

On May 18, 2020, the Board dismissed the DSH SSI Percentage (Provider Specific) issue in its entirety.[3] Accordingly, Issue 3 (the Medicaid Eligible Days issue) is currently the sole issue pending in the Case.

On December 30, 2019, pursuant to the regulations governing discovery in Board proceedings, WPS sent its request to the Provider for certain documents and for responses to written interrogatories.[4] On March 23, 2020, the Provider responded to WPS's interrogatories. However, WPS was dissatisfied with Provider's responses. Accordingly, on March 30, 2020, WPS filed a Motion to Compel Discovery ("WPS Motion") with the Board. The Provider did not submit a filing to oppose the MAC's Motion to Compel.

On September 23, 2020, the Board granted the MAC's Motion to Compel Discovery, and issued an Order to that effect. On October 30, 2020, the MAC filed a Motion to Dismiss Appeal, noting that the Provider has failed to furnish documentation or information, communicate with the MAC regarding the Order or otherwise respond to the Board's September 23, 2020 Order.[5] Again, the Provider did not submit a filing to oppose the MAC's Motion to Dismiss.

The MAC's Motion to Dismiss, filed October 30, 2020, asserts the following:

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[2] *Id.*
[3] *See* PRRB Jurisdictional Decision (May 18, 2020).
[4] MAC's DSH Medicaid Eligible Days Documentation Request (Dec. 30, 2019).
[5] MAC's Motion to Dismiss Appeal, at 2 (Oct. 20, 2020).

- On September 23, 2020, the Board granted the MAC's Motion to Compel Discovery and ordered the Provider to furnish information and documentation to the MAC *within thirty (30) days* in accordance with the Board's Order;

- In its Order, the Board noted that the Provider did not file a response to the MAC's Motion to Compel Discovery;

- To date, the Provider has failed to furnish documentation or information, communicate with the MAC regarding the Order or otherwise respond to the Board's September 23, 2020 Order.[6]

## II. Authorities Governing Discovery and Dismissal in Board Proceedings

The Secretary of Health and Human Services' ("HHS") promulgated regulations governing Board appeals and proceedings at 42 C.F.R. Part 405, Subpart R. In particular, 42 C.F.R. § 405.1853 addresses discovery and limits discovery in Board proceedings to "discovery of a matter that is relevant to the specific subject matter of the Board hearing, provided that the matter is not privileged or otherwise protected from disclosure and the discovery request is not unreasonable, unduly burdensome or expensive, or otherwise inappropriate."[7] In addition, for any discovery that is permitted under the regulations or ordered by the Board "[t]he applicable provisions of the Federal Rules of Civil Procedure and Rules 401 and 501 of the Federal Rules of Evidence serve as guidance[.]"[8]

The Board's authority regarding discovery prior to a Board hearing is governed by 42 C.F.R. § 405.1853(e). The regulations provide, generally:

> (1) *General rules.*
>
> (i) Discovery is limited in Board proceedings.
>
> (ii) The Board may permit discovery of a matter that is relevant to the specific subject matter of the Board hearing, provided the matter is not privileged or otherwise protected from disclosure and the discovery request is not unreasonable, unduly burdensome or expensive, or otherwise inappropriate.
>
> (iii) Any discovery initiated by a party must comply with all requirements and limitations of this section, and with any further requirements or limitations ordered by the Board.

[6] MAC's Motion to Dismiss Appeal, at 2 (Oct. 20, 2020).
[7] 42 C.F.R. § 405.1853(e)(1) (i), (iv).
[8] *Id*. Rule 401 of the Federal Rules of Evidence sets out a test for relevant evidence that states that evidence is relevant if it has a tendency to make a fact more or less probable than it would be without the evidence and the fact is of consequence in determining the action. Rule 501 of the Federal Rules of Evidence states that the common law, as interpreted by United States courts, governs a claim of privilege unless any of the following provides otherwise: the United States Constitution; a federal statute; or rules prescribed by the Supreme Court.

> (iv) The applicable provisions of the Federal Rules of Civil Procedure and Rules 401 and 501 of the Federal Rules of Evidence serve as guidance for any discovery that is permitted under this section or by Board order.[9]

And provide the following limitations:

> (2) *Limitations on discovery.* Any discovery before the Board is limited as follows:
>
> (i) A party may request of another party, or of a nonparty other than CMS, the Secretary or any Federal agency, the reasonable production of documents for inspection and copying.
>
> (ii) A party may also request another party to respond to a reasonable number of written interrogatories.
>
> (iii)(A) A party may not take the deposition, upon oral or written examination, of another party or a nonparty, unless the proposed deponent agrees to the deposition or the Board finds that the proposed deposition is necessary and appropriate under the criteria set forth in Federal Rules of Civil Procedure 26 and 32(a)(3) in order to secure the deponent's testimony for a Board hearing.
>
> (B) The regulations at 45 CFR Part 2 (Testimony by employees and production of documents in proceedings where the United States is not a party) apply as to whether an employee or officer of CMS or HHS will appear for a deposition.
>
> (iv) A party may not request admissions or take any other form of discovery not authorized under this section.[10]

Motions to compel are governed by the same regulation:

> (5) *Motions to compel or for protective order.* (i) Each party is required to make a good faith effort to resolve or narrow any discovery dispute, regardless of whether the dispute is with another party or a nonparty.
>
> (ii) A party may submit to the Board a motion to compel discovery that is permitted under this section or any Board order, and a party or nonparty may submit a motion for a protective order regarding any discovery request to the Board.
>
> (iii) Any motion to compel or for protective order must include a self-sworn declaration describing the movant's efforts to resolve or narrow the discovery dispute.
>
> (iv) A self-sworn declaration describing the movant's efforts to resolve or narrow the discovery dispute must be included with any response to a motion to compel or for protective order.

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[9] 42 C.F.R. § 405.1853(e)(1).
[10] 42 C.F.R. § 405.1853(e)(2).

> (v) The Board must decide any motion in accordance with this section and any prior discovery ruling.
>
> (vi)(A) The Board must issue and mail to each party and any affected nonparty a discovery ruling that grants or denies, in whole or in part, the motion to compel or the motion for a protective order, if applicable.
>
> (B) The discovery ruling must—
>
> (*1*) Specifically identify any part of the disputed discovery request upheld and any part rejected, and
>
> (*2*) Impose any limits on discovery the Board finds necessary and appropriate.
>
> (vii) Nothing in this section authorizes the Board to compel any action from the Secretary or CMS.[11]

The Board's authority regarding the power to dismiss an appeal, for violation of, or failure to follow, a Board rule or order, is governed by 42 C.F.R. § 405.1868. The regulation provides:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may –
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the Provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.[12]

Pursuant to the regulatory authority granted in 42 C.F.R. § 405.1868(b), the Board grants WPS's Motion to Dismiss Appeal for the Provider's failure to comply with the Board's Order to Compel. In this regard, the Board notes that the requested discovery (*i.e.*, requested documents and responses to interrogatories) go to the heart of the sole issue remaining in this case.[13] The Provider's initial response to the discovery request March 23, 2020 was insufficient as it was unresponsive to the discovery. As a result, the MAC filed the Motion to Compel which led to the Board Order to Compel. Therein, the MAC documents the Providers failure to fulfill its obligation under 42 C.F.R. § 405.1853(e)(5) "to make a good faith effort to resolve or narrow

[11] 42 C.F.R. § 405.1853(e)(5).
[12] 42 C.F.R. § 405.1868(a)-(b).
[13] *See* Order to Compel at ¶¶ 2-10.

any discovery dispute."[14] In fact, the Provider has since been wholly nonresponsive, including: (1) failing to respond to the Motion to Compel; (2) failing to respond to or comply with the ensuing Order to Compel (including not responding to the MAC's efforts to communicate following the Order[15]); and (3) failing to respond to the MAC's Motion to Dismiss. Accordingly, the Board must also conclude that the Provider has abandoned this appeal.[16]

In summary, as the Provider failed to comply with the Board's Order and has abandoned the case, the Board hereby dismisses Case No. 19-1833 with prejudice and removes it from the Board's docket pursuant to its authority under 42 C.F.R. § 405.1868(b). 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.

<u>Board Members</u>

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert Evarts, Esq.
Susan Turner, Esq.

FOR THE BOARD

2/17/2021

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

cc: Wilson Leong, Federal Specialized Services

[14] *See* MAC Motion to Compel at ¶¶ 4-11 (documenting the MAC's attempts over the course of a year to obtain information on the 50 days claimed by the Provider).
[15] *See* MAC Motion to Dismiss Appeal at 2 (stating "To date, the Provider has failed to furnish documentation or information, communicate with the MAC regarding the Order or otherwise respond to the Board's September 23, 2020 Order.").
[16] *See* Board Rule 41.2.

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

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**Via Electronic Delivery**

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RE: ***Jurisdictional Decision***
McLeod Loris/Seacoast Hospital
FYE 9/30/2017
Case No. 17-1148

Dear Mr. Hettich,

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

**Pertinent Facts:**

The Provider filed its appeal request on February 17, 2017, challenging the Final Rule in the Federal Register issued on August 22, 2016.[1] The Provider's appeal focuses on whether its DSH payment contained a calculation error related to the third factor ("Factor 3") used to determine the payment for its proportion of uncompensated care. Specifically, the Provider has framed two issues as follows:

> *Issue 1:* Whether CMS's failure to exclude the time period for which a hospital had no Medicaid eligible days and failure to use a full 12-month cost reporting period to determine the number of the Provider's Medicaid eligible days in calculating a portion of Factor 3 of the Provider's FY 2017 uncompensated care ("UCC") payment was lawful?
>
> *Issue 2:* Whether CMS erred and acted beyond its authority, i.e., *ultra vires*, by failing to effectuate the D.C. circuit's *Allina* decision when it calculated factor 3 in the Provider's UCC payment.[2]

For Issue 1, the Provider points out that, for FY 2017, CMS stated it would average the data from the FY 2011, 2012, and 2013 cost reports to determine a provider's Factor 3 value, and that, if a hospital did not have data for one or more of those periods, CMS would compute Factor 3 for the periods available and average those. Provider goes on to note that it underwent a change in

[1] Individual Appeal Request, Tab 1 (Feb. 17, 2017); 81 Fed. Reg. 56762 (Aug. 22, 2016).
[2] Individual Appeal Request, Tab 3 at 1-3.

ownership ("CHOW") in 2012 and, as such, there are no FY 2011 Medicaid eligible days data available for the Provider's newly assigned Provider Number that resulted from that CHOW. Nevertheless, Provider claims that, rather than exclude FY 2011 because no data was available, CMS included a "zero" for FY 2011 when averaging its Medicaid eligible days cost report data.[3]

Furthermore, CMS used the Medicaid days from a shortened cost reporting period ("stub-period") for FY 2012 to calculate its UCC adjustment amount. Provider claims that CMS is statutorily required to calculate the UCC payment for each hospital "for a period selected by the Secretary," and that comparing the days in a stub-period for Provider to a full twelve-month period for other providers employs different "periods" in violation of that statutory requirement.[4] Provider also argues that the use of a stub-period violates the statutory requirement that any "estimate" used by the Secretary be "based on appropriate data." It claims that this practice arbitrarily penalizes certain providers with "stub-periods."[5] Finally, Provider argues that it is not being provided the same protection afforded to Indian Health Service ("IHS") hospitals. It notes that, originally, because cost reports for IHS hospitals are not uploaded to HCRIS, the UCC payments calculated by CMS understated the amount of uncompensated care that IHS hospitals provide. CMS later revised its policy to consider supplemental cost report data in determining Factor 3 to allow the Medicaid days for HIS hospitals to be included.[6]

For Issue 2, Provider discusses *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) ("*Allina*") with regard to the calculation of Factor 3 of the UCC payment, reiterating the argument that SSI days should exclude Medicare Advantage ("MA") days, and MA dual eligible days should be included as Medicaid days in the FY 2017 Factor 3 calculation. Provider points out CMS' position that it does not believe *Allina* has any bearing on the estimate of Factor 3 for FY 2017 since it had readopted the policy of counting MA says in the SSI fraction for FY 2014 and beyond. Provider argues that this policy still relies on SSI and Medicaid data from a period predating this re-adopted policy, and that CMS was obligated to correct those numbers to conform with the Court's ruling in *Allina.* Provider contends that this approach results in CMS acting beyond its authority by continuing to treat Part C days as "days entitled to benefits under Part A" for periods pre-dating their re-adopted policy.[7]

The Medicare Contractor ("MAC") filed a Jurisdictional Challenge in this case on August 1, 2018. The MAC argues that both issues are precluded from administrative and judicial review pursuant to 42 U.S.C. § 1395ww(r)(3). It argues that the "bar against administrative and judicial review is sufficiently broad to defeat the provider's arguments concerning the cost reporting periods used in CMS's calculation and the provider's argument that the agency continues to place the Medicare Part C days in the wrong fraction."[8]

The Provider filed a Response to the MAC's Jurisdictional Challenge on August 20, 2018. It argues that CMS failed to use "appropriate data" in calculating Factor 3 for its FY 2017 UCC

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[3] *Id.* at 1-2.
[4] *Id.* at 3.
[5] *Id.*
[6] *Id.* (citing 78 Fed. Reg. 61191, 61195 (Oct. 3, 2013)).
[7] *Id.* at 2-3. *See also* 79 Fed. Reg. 49853.
[8] Medicare Administrative Contractor's Jurisdictional Challenge at 2 (Aug. 1, 2018).

DSH payment as required by section 1886(r) of the Social Security Act because its own policy required that data be used from FYs 2011, 2012, and 2013 "when applicable," but that, due to a change in ownership, Provider had no data for FY 2011. The Provider argues that CMS should have excluded FY 2011 from its UCC DSH payment calculation rather than include a "zero" in the average.[9] It points to language from the Federal Register stating that "if the hospital does not have data for one or more of the three cost reporting periods, [CMS] will compute Factor 3 for the periods available and average those."[10] The Provider insists that it is not challenging the estimates made or time period selected in calculating Factor 3, but rather CMS' failure to follow its own policy in calculating its Medicaid-eligible days.[11] Finally, Provider states that CMS has acted *ultra vires* by counting patient days under Part C as "days entitled to benefits under Part A" in calculating its SSI ratio, contrary to the holding in *Allina*.[12]

**Relevant Law:**

Bar on Administrative Review

The Board finds that it does not have jurisdiction over either aspect of the Uncompensated Care DSH payment issue in the above-referenced appeal based on 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) which preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[13]
(B) Any period selected by the Secretary for such purposes.

Further, in 2016, the D.C. Circuit Court[14] upheld the D.C. District Court's decision[15] that there is no judicial or administrative review of uncompensated care DSH payments. In *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"), the provider challenged the calculation of the amount it would receive for uncompensated care for FY 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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[9] Provider's Jurisdictional Response at 1 (citing 81 Fed. Reg. 56762, 56957-56958 (Aug. 22, 2016)).
[10] *Id.*
[11] *Id.* at 4.
[12] *Id.* at 2, 6.
[13] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[14] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[15] 89 F. Supp. 3d 121 (D.D.C. 2015).

The District Court found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[16] The D.C. Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[17]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[18]

The D.C. Circuit Court addressed the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH Regional*").[19] In *DCH Regional*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[20] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that the D.C. Circuit had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, it found the same relationship existed with regard to the methodology used to generate the estimates.[21]

Recently, in *Scranton Quincy Hospital Co. v. Azar*,[22] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[23] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from FY 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on

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[16] 830 F.3d 515, 517.
[17] *Id.* at 519.
[18] *Id.* at 521-22.
[19] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[20] *Id.* at 506.
[21] *Id.* at 507.
[22] No. 18-32310 (ABJ) (consolidated 19-cv-1602), 2021 WL 65449 (D.D.C. Jan. 7, 2021) ("*Scranton*").
[23] *Id.* at *3.

either the FY 2012 or 2011 cost report that was closest to a full twelve month cost report.[24] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[25] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[26]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH Regional*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[27]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[28] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* case were not met.[29] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[30]

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

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[24] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[25] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[26] *Id.*
[27] *Id.* at *9.
[28] *Id.* at *10.
[29] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[30] *Id.* (quoting *DCH v. Azar*, 925 F.3d at 509-510).

which requires a violation of a clear statutory command.[31] The court ultimately upheld the Board's decision that it lacked jurisdiction to consider the Providers' appeals.

Announced Methodology for Factor 3 Calculation

When the Secretary began implementing the Uncompensated Care payments ahead of FY 2014, she proposed to estimate Factor 3 values based on the most recently available full year cost report data with respect to a federal fiscal year. For FY 2014, the Secretary used data from the 2010/2011 cost reports to estimate Factor 3.[32] For FY 2015, the Secretary maintained this approach and estimated the values for Factor 3 calculations based on the 2011/2012 cost reports, using 2012 unless that cost report was unavailable or reflected less than a full 12-month year, in which case the cost report from FY 2012 or 2011 that was closest to being a full 12-month cost report was used.[33] For FY 2016, the Secretary opted to use more recently updated data from the same FY 2012 or 2011 cost reports, noting that more recent cost reports may be available, but that these FYs would be more accurate since they had continued to be updated.[34]

Beginning with FY 2017, the Secretary changed her policy of using only one cost reporting period to determine a hospital's share of uncompensated care. She chose to expand the time period for the data used to calculate Factor 3 from one cost reporting period to three cost reporting periods. For FY 2017, the Secretary announced she would use an average of the data from hospitals' FY 2011, 2012, and 2013 cost reporting periods for Factor 3. The Secretary clarified "that if the hospital does not have data for one or more of the three cost reporting periods, [CMS] will compute Factor 3 for the periods available and average those. In other words, [CMS] will divide the sum of the individual Factor 3s by the number of cost reporting periods for which there are data. [35]

**Board Decision:**

With regard to any argument that the Secretary could have used more accurate or recent data to calculate any portion of Provider's 2017 Uncompensated Care payments, the Board finds that the same findings from *Tampa General* are applicable. The Provider is challenging the inclusion and/or exclusion of certain days and/or data in the estimates used by the Secretary, as well as the use of a stub-period cost report. The Board finds in challenging data included or excluded in calculating its Factor 3 values, the Provider is seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board finds in essence, the Provider is challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well. Furthermore, in challenging the Medicare Contractor's use of a stub-period cost report covering one time period, rather than a twelve-month cost report covering a different period, the Provider is challenging the "period selected by the Secretary" used in creating those estimates, which is

[31] *Id.* at *11 (quoting *DCH v. Azar*, 925 F.3d at 509).
[32] 78 Fed. Reg. 50495, 50638 (Aug. 19, 2013).
[33] 79 Fed. Reg. 49853, 50018-50019 (Aug. 22, 2014).
[34] 80 Fed. Reg. 49325, 49528 (Aug. 17, 2015).
[35] 81 Fed. Reg. 56762, 56957-56958 (Aug. 22, 2016).

also barred from review. Similarly, as the D.C. Circuit stated in *DCH Regional*, "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."[36]

Likewise, with regard to the argument that the Medicare Contractor should have excluded FY 2011 from its UCC DSH payment calculation, rather than include a "zero" in the average, the Board finds that it does not have jurisdiction to review this. While the Provider is not challenging any "estimate" or "period" which was actually chosen by the Secretary to calculate its 2017 Uncompensated Care payments, but rather the Medicare Contractor's alleged deviation from CMS' stated policy for making the calculation, the D.C. District Court held in *Scranton* that such a challenge is still barred from review, succinctly stating that any argument "that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[37]

Finally, the Board notes that its decision is consistent with the D.C. Circuit's interpretation of the subject statutory provisions in *Tampa General* and *DCH Regional* and that these decisions are controlling precedent because the Providers may bring suit in the D.C. Circuit.[38]

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.

<u>Board Members Participating</u>:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

2/18/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Laurie Polson, Palmetto GBA c/o National Government Services, Inc. (J-M)

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[36] *Id.* at 506.
[37] *Scranton* at *10.
[38] 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**

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**Via Electronic Delivery**

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**RE:** ***Jurisdiction Decision in Part***
Sutter Tracy Community Hospital (Prov. No. 05-0313; FYE 12/31/2011)
Case No. 15-2509

Dear Mr. Jaeger and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the Disproportionate Share Hospital ("DSH") SSI Ratio, Realignment issue because it is duplicative of the DSH – SSI Ratio, Accurate Data issue that was transferred to group Case No. 17-1076GC and there is no final determination with respect to the request for realignment. The jurisdictional decision of the Board is set forth below.

**Pertinent Facts:**

On October 30, 2014, the Provider was issued an original Notice of Program Reimbursement ("NPR") for fiscal year ending December 31, 2011.

The Provider filed an individual appeal request with the Board on April 28, 2015. The Individual Appeal Request contained ten (10) issues which all concerned components of the Medicare disproportionate share percentage:

Issue 1: Medicare DSH – SSI Ratio, Realignment
Issue 2: Medicare DSH – SSI Ratio, Accurate Data
Issue 3: Medicare DSH – Inclusion of Medicare Part C Mngd. Care Days in SSI Ratio Issued 3/ 2012
Issue 4: Medicare DSH – Inclusion of Medicare Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012
Issue 5: Medicare DSH – SSI MMA § 951 Applicable to SSI Ratio Issued March 2012
Issue 6: Medicare DSH – Medicaid Eligible Days, Restricted Aid Codes (RAC) 2 and 3
Issue 7: Medicare DSH – Medicaid FFP Eligible Patient Days-Emergency Restricted Aid Codes MB 2, 3
Issue 8: Medicare DSH Understated – Dual Eligible Part C
Issue 9: Medicare DSH Understated – Dual Eligible Part A Exhausted
Issue 10: Medicare DSH – Medicaid Eligible Days, Administrative Days and Medicaid HMO Days

The Provider has since requested to transfer 8 of the 10 issues to group appeals, including Issue 2 entitled "SSI Ratio, Accurate Data" to Case No. 17-1076GC, Sutter Health 2011 DSH – SSI Ratio Inaccurate Data CIRP Group. Only two issues remain pending in this appeal, namely:

Issue 1: DSH – SSI Ratio Realignment; and
Issue 10: DSH – Medicaid Eligible Days, Administrative Days and Medicaid HMO Days.

For the DSH – SSI Ratio Realignment issue, the Provider contended that the "SSI percentage as generated by the Social Security Administration (SSA) and put forth by CMS is understated." As a result, the Provider requested to realign the SSI percentage from the federal fiscal year to using the Provider's fiscal period.

**Board Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board is dismissing the Medicare DSH – SSI Ratio, Realignment. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Medicare DSH – SSI Ratio, Accurate Data issue in Case No. 17-1076GC to which the Provider was directly added to on September 22, 2017. The DSH – SSI Ratio, Realignment issue in the present appeal concerns how the SSI percentage was generated by the Social Security Administration (SSA). The Provider asserts that "the SSI percentage as generated by the [SSA] and put forth by CMS is understated" pursuant to 42 U.S.C. § 1395ww(d)(5)(F). Since the Provider is required to use the SSI percentage assigned by CMS rather than using an internally generated SSI percentage, the Provider contends that it "validly self-disallowed such an internally generated percentage in favor of that promulgated by CMS."[1]

The Provider's DSH – SSI Ratio, Accurate Data issue in group Case No. 17-1076GC also alleged that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage due to a number of factors. The Provider further contends that the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the Medicare DSH – SSI Ratio, Realignment issue in this appeal is duplicative of the Medicare DSH – SSI Ratio, Accurate Data issue in Case No. 17-1076GC.[2] Because the issue is duplicative, and

[1] Sutter Tracy Community Hospital, Statement of Appeal Issues at 2 (April 28, 2015).
[2] The aspect of Issue 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is contained in the first four paragraphs of Issue 1 and these first four paragraphs are identical to the first four paragraphs of Issue 2 that was transferred to Case No. 17-1076GC.

duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5 (2015), the Board dismisses this aspect of the DSH/SSI Percentage (Provider Specific) issue.[3]

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

**Conclusion**

The Board finds that it does not have jurisdiction over the DSH – SSI ratio, Accurate Data issue and dismisses the issue from this appeal. Case No. 15-2509 remains open given that another issue, DSH – Medicaid Eligible Days, Administrative Days and Medicaid HMO Days, remains pending in the appeal.

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

Board Members Participating:

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For the Board:

2/19/2021

X Clayton J. Nix

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

[3] Moreover, the Board notes that in the appeal request filed on April 28, 2015, the Provider recognized that Issue 1 was an issue "common to other related parties and Sutter Health will transfer this issue into its mandatory common issue related party (CIRP) group appeal subsequent to this individual request." However, more than 5 ½ years later, the Provider has failed to transfer this issue notwithstanding its recognized obligation under 42 C.F.R. § 405.1837(b)(1). As such, the Board must assume it is the same issue that was transferred to Case No. 17-1076GC and has otherwise been abandoned as an alleged separate "common issue."

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

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RE: ***Jurisdictional Determination***
Duke University CY 2006 SSI Percentage CIRP Group
Case No. 21-0099GC

Dear Ms. Webster and Ms. Polson:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced group appeal and finds an impediment to jurisdiction. The pertinent facts of the case and the jurisdictional decision of the Board, are set forth below.

**Pertinent Facts:**

Ropes & Gray, LLP ("Ropes & Gray") filed the subject group appeal on March 23, 2020. The issue statement indicates the group is appealing:

> . . . whether the Centers for Medicare & Medicaid Services ("CMS") has correctly determined the number of patient days counted in the numerator of the "Medicare Part A/SSI fraction" used in calculating the Provider's disproportionate patient percentages for purposes of the DSH adjustment. The Providers contend that the Medicare Part A/SSI Fraction is understated to the extent that CMS has not corrected systemic flaws in the data and match process used by CMS in determining the Medicare Part A/SSI fractions. ("SSI – Baystate Errors")

The group was formed with:

**Participant 1: Duke Regional Hospital (34-0155) 6/30/2006 (Direct Add 3/23/2020)**

- Reopening Requests dated December 3, 2007 and a follow up request to CMS dated April 24, 2013 (which the MAC also forwarded to CMS on July 11, 2014),
  - Original Reopening included the following language:
    The Provider ". . .requests a recalculation of the SSI percentage based on the Hospital Fiscal Year ended June 30, 2006."

- Revised NPR dated September 23, 2019
- Audit Adjustments 25 & 46: Both were made to adjust the Provider's SSI % based on CMS' recalculation which is based on the Provider's fiscal year instead of the federal fiscal year.

Subsequently, Ropes and Gray added an additional Provider to the group on April 17, 2020 which became the second participant in the group:

**Participant 2: Duke Raleigh Hospital (34-0073) FYE 6/30/2006 (Direct Add 4/17/2020)**

- Reopening Requests dated December 3, 2007 and a follow up request to CMS dated April 24, 2013,
  - Original Reopening included the following language: The Provider ". . . requests a recalculation of the SSI percentage based on the Hospital Fiscal Year ended June 30, 2006."
- Notice of Reopening dated September 20, 2019
  - The cost report is being reopened for the following issue: Provider's requested SSI% recalculation based on the provider's FYE. To ensure proper reporting of the SSI ratio and the Medicare DSH percentage on the cost report based on CMS' recalculation."
- Revised NPR dated October 22, 2019
- Audit Adjustment 4, 5, 7: To adjust the SSI % to CMS' determination which is based on the Provider's fiscal year instead of the federal fiscal year and to adjust the DSH payment factor based on the revised SSI %.

**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.

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

> (a) *General*. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, with respect to specific findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor

> (with respect to contractor determinations), or by the reviewing entity that made the decision. . . .

Additionally, 42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:

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

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) 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 must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[1]

[1] (Emphasis added.)

The Board finds that it does not have jurisdiction over the SSI Baystate issue for the two Providers in this group (Duke Regional Hospital and Duke Raleigh Hospital) that filed from revised NPRs because the revised NPRs were issued as a result of the Providers' SSI Realignment requests, and did not adjust the SSI Baystate issue, which is the issue under appeal in this group. In this regard, the Board notes that, in the FY 2011 IPPS Final Rule (following the April 28, 2010 issuance of CMS Ruling 1498-R), CMS adopted a revised data matching process to determine the SSI fraction and CMS adopted this revised data matching process as part of its implementation of the district court decision in *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008). The Providers are alleging that there are certain "flaws" in this revised data matching process.

42 C.F.R. § 405.1889)b)(1) specifies that, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[2] Here, the notice of reopening for both of these participants states that the purpose of the reopening was to realign their SSI percentages from the federal fiscal year end to the individual cost reporting fiscal year ends. To this end, the audit adjustments associated with the revised NPRs under appeal for both participants only revised the SSI percentages in order to realign them from a federal fiscal year to the providers' respective fiscal years (e.g., the Audit Adjustment No. 4 for Duke Health Raleigh Hospital reads: "To adjust the SSI% to CMS's determination which is based on the provider's fiscal year instead of the federal fiscal year").[3] In other words, the determinations were only being reopened to include the realigned SSI percentages where the SSI percentages were realigned from the federal fiscal year to the provider's respective fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[4] Since

[2] 42 C.F.R. § 405.1889(b)(1).

[3] The Board has not identified evidence in the record to establish that CMS did not follow its realignment process as described in the Federal Register when CMS issued the realigned SSI fractions used in the revised NPRs at issue. *See infra* note 4.

[4] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis through that data matching process remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must***

the only matters specifically revised in the revised NPRs were adjustments related to the realigning the SSI percentages from federal fiscal year to provider fiscal year, the Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the SSI Baystate issue. Accordingly, the Board does not have jurisdiction over these two participants in the group. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[5]

In conclusion, Duke Regional Hospital and Duke Raleigh Hospital are dismissed from the appeal as they do not have the right to appeal the revised NPRs at issue under §§ 405.1889(b) and 405.1835(a)(1). As there are no remaining participants in the group, the Board closes the group and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

2/23/2021

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

***accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[5] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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RE: ***Jurisdictional Determination***
Cleveland Clinic Fdn. CY 2006 DSH Medicaid Fraction Dual Eligible Days CIRP
Case No. 20-1373GC

Dear Ms. Goron and Ms. Cummings:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced common issue related party ("CIRP") group appeal and finds an impediment to jurisdiction. The pertinent facts of the case and the jurisdictional decision of the Board, are set forth below.

**Pertinent Facts:**

The subject group appeal was filed by Healthcare Reimbursement Services, Inc. ("HRS" or "Representative") on March 6, 2020. The group issue statement indicates the group is appealing

> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Part A did not make a payment.

The initial participants forming the group (both of which were directly added to the group) were:

- **Fairview Hospital (Prov. No. 36-0077)** filed from a revised NPR dated September 4, 2019. Although a copy of the Reopening request was not provided, the Notice of Reopening was issued on November 14, 2016. The Notice indicates the cost report was reopened "[t]o update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 11/09/2016." According to the audit adjustment support included, the referenced audit adjustment (#1) was made "[t]o update the SSI % and payment factor in accordance with CMS' SSI realignment calculation."

- **Lutheran Hospital (Prov. No. 36-0087)** filed from a revised NPR dated September 4, 2019. Although a copy of the Reopening request was not provided, the Notice of Reopening was issued on November 14, 2016. The Notice indicates the cost report was reopened "[t]o update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 11/09/2016." According to the audit adjustment support included, the referenced audit adjustment (#1) was made "[t]o update the SSI % and payment factor in accordance with CMS' SSI realignment calculation."

In accordance with Board Rule 15.2, the MAC performed its initial review of the group and, in a letter dated March 24, 2020, it alerted the Board to jurisdictional impediments for the two participants that formed the group. The MAC contends that it did not make any adjustments to the Medicaid Fraction Dual Eligible Days issue for either Provider in the revised NPRs. It merely changed the SSI fraction period form the Federal Fiscal Year to the Providers' cost reporting year end based on the Providers' requests.

**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.

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

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

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) 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 must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[1]

The Board finds that it does not have jurisdiction over the DSH Medicaid Fraction Dual Eligible Days issue for these two participants, Fairview Hospital and Lutheran Hospital, both of which appealed from revised NPRs, because neither participant has appeal rights under 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b) to appeal the revised NPRs at issue. The revised NPRs were issued as a result of the Providers' SSI Realignment requests, and did not adjust the DSH Medicaid Fraction Dual Eligible Days issue, which is the issue under appeal in this group.

42 C.F.R. 405.1889(b)(1) specifies that, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[2] The reopening for both of these participants were issued as a result of the Providers' requests to realign their SSI percentages from the federal fiscal year end to the individual cost reporting fiscal year ends. To this end, the audit adjustments associated with the

[1] (Emphasis added.)
[2] 42 C.F.R. § 405.1889(b)(1).

revised NPRs under appeal for both participants clearly only revised the SSI percentages in order to realign them from a federal fiscal year to the providers' respective fiscal years. In other words, the determinations were only being reopened to include the realigned SSI percentages where the SSI percentages were realigned from the federal fiscal year to the provider's respective fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[3] Since the only matters specifically revised in the revised NPRs were adjustments related to the realigning the SSI percentages from the federal fiscal year to the provider fiscal year, the Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the DSH Medicaid Fraction Dual Eligible Days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[4]

In conclusion, Fairview Hospital and Lutheran Hospital are dismissed from the appeal as they do not have the right to appeal the revised NPRs at issue §§ 405.1889(b) and 405.1835(a)(1). As there are no remaining participants in the group, the Board hereby closes Case No. 21-0099GC and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

2/24/2021

X Clayton J. Nix

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

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

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[3] 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). However, CMS does not utilize the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).
[4] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).