DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Mail

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

RE: ***Denial of Motion to Reinstate***
Pitt County Memorial Hospital (34-0040)
FYE 9/30/2009
Case No. 14-2001

Dear Ms. Webster,

The Provider Reimbursement Review Board ("Board") has reviewed the letter requesting reinstatement ("Motion for Reinstatement") submitted by Pitt County Memorial Hospital ("Provider") on August 29, 2019. The decision of the Board is set forth below.

Pertinent Facts:

The Provider filed an Individual Appeal Request on January 27, 2014 from a Notice of Program Reimbursement ("NPR") dated August 1, 2013, for fiscal year ending September 30, 2009. The original appeal contained two issues: DSH/Medicaid Paid/Eligible Days, and Total Patient Days. On August 24, 2016, the Board received Provider's Withdrawal of Appeal Pursuant to Reopening Agreement ("Withdrawal") in which they withdrew both issues based on the Medicare Contractor's agreement to reopen the cost report. The Withdrawal also included a copy of the Medicare Contractor's Notice of Reopening, which indicated the cost report was being reopened for the following relevant issues:

1. To review additional Medicaid eligible days . . . .
2. To review days included in Medicaid days . . . that have been identified as not being allowable for DSH purposes . . . .

The Provider reserved the right, under Board Rule 46.2 (2015), to request reinstatement of both issues within three years if the Medicare Contractor did not effectuate a reopening and issue a revised determination. The Board granted the request to withdraw the appeal on August 29, 2016.

On August 29, 2019, Provider filed a Motion for Reinstatement of Appeal requesting to reinstate the DSH eligible days issue because, while the Medicare Contractor issued a revised NPR on March 27, 2019, they only included a portion of the Medicaid-eligible days identified by the Provider. As such, the Provider is requesting the issue be reinstated so they may pursue the remaining Medicaid-eligible days not included in the March 2019 revised NPR. The Motion for

Reinstatement also included copies of the Provider's request to reopen the cost report and the Medicare Contractor's agreement to do so.

On September 26, 2019, the Board received an Objection to Provider's Motion for Reinstatement filed by the Medicare Contractor, who notes that the Board Rules require a motion for reinstatement to set forth the reasons for reinstatement, and that the motion will not be granted if the Provider is at fault. The Medicare Contractor's position is that they agreed to reopen the cost report to review additional Medicaid eligible days for inclusion, **not** to include 100 percent of the days requested by the Provider. They go on to explain that the Provider submitted documentation for a sample of patient days, and that the documentation was insufficient to support the entire length of stay claimed. Since the Provider did not submit the necessary documentation to support their requested days, the Medicare Contractor argues that the Provider is at fault for the failure to receive all of its requested days.

The Board also received a "Request for Hearing and Consolidation of Appeal" on September 23, 2019 from the Provider's revised NPR, which seeks to consolidate that new appeal with the instant case, if reinstated.

Statutory and Regulatory Background

A Medicare Contractor may reopen a cost report within three years of the date of the NPR.[1] A provider may withdraw an issue in an appeal for which the Medicare Contractor has agreed to reopen the final determination (*i.e.*, the cost report).[2] Following such a withdrawal, the provider may file a motion for reinstatement within three years of withdrawing the issue pursuant to Board Rule 47.2.2:

> Upon written motion, the Board will also grant reinstatement of an issue(s)/case if a provider requested to withdraw an issue(s) from its case because the Medicare contractor agreed to reopen/revise the cost report for that issue(s) but failed to reopen the cost report and issue a new final determination (e.g., Revised NPR) for that issue(s) ***as agreed***. In its motion for reinstatement, the provider ***must attach*** a copy of its reopening request and the correspondence from the Medicare contractor where the Medicare contractor agreed to reopen the final determination for that issue(s).[3]

Thus, pursuant to this Rule the motion must be in writing and include copies of the provider's reopening request and the Medicare Contractor's agreement to reopen the final determination. Further, the Board will grant the motion for reinstatement of the withdrawn issue/case if the

[1] 42 C.F.R. § 405.1885.
[2] Board Rule 46.
[3] (Emphasis added.)

Medicare Contractor fails to reopen the cost report and issue a revised NPR for that issue "as agreed."

Board's Decision:

Pursuant to Board Rule 47.1, the Provider has filed for reinstatement within three years of withdrawal. In its request for reinstatement, the Provider Representative states the following:

> By letter dated August 29, 2016, the Board granted the Provider's request to withdraw this appeal following the MAC'S agreement to reopen the cost report to correct the amount of Medicaid-eligible days in the DSH calculation. On March 27, 2019, the MAC issued a revised NPR that included a portion of the additional Medicaid-eligible days identified by the Provider, *but declined to include all the additional Medicaid-eligible days presented by the Provider for inclusion in the DSH calculation*. Accordingly, the Provider requests that the appeal be reinstated so it can continue to pursue through the appeals process the remaining Medicaid-eligible days not included in the March 2019 revised NPR. *Pursuant to Board Rule 47.2.2, the Provider's request to reopen the cost report and* ***the MACs agreement to reopen*** *the cost report are enclosed with this letter*.[4]

The MAC agreement attached to the reinstatement request is a notice of reopening from the MAC dated June 17, 2016. In this notice, the MAC reopened the Provider's cost report: (1) "[t]o ***review*** additional Medicaid eligible days . . . *and to adjust* the applicable components of the DSH calculation ***based on the results of the review***."[5] The Provider is requesting reinstatement because, even though the MAC reopened and issued a revised NPR that "included a portion of the additional Medicaid-eligible days presented by the Provider for inclusion in the DSH calculation," it desired "pursue through the appeals process the remaining Medicaid-eligible days not included in the March 2019 revised NPR."

The Board hereby denies the request to reinstate Case No. 14-2001 because the criteria laid out in Board Rule 47.2.2 was not met. In this regard, it is clear that the Medicare Contractor has, in fact, reopened and issued a revised NPR for the issues "as agreed" and that potential reinstatement under Board Rule 47.2.2 was extinguished when the Medicare Contractor issued a new determination that specifically dealt with the issues for which the Provider is seeking reinstatement.

[4] (Emphasis added.)
[5] (Emphasis added.)

The Board notes that the Provider has filed an individual appeal request from the revised NPR. Consequently, the Board will process that appeal request and issue a new case number under separate cover subject to Board's governing statute and regulations.

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

Board Members Participating:

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

For the Board:

3/6/2020

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.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
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Via Electronic Delivery

Leslie Demaree Goldsmith, Esq.
Baker, Donelson, Bearman, Caldwell & Berkowitz
100 Light Street
Baltimore, MD 21202

RE: ***Expedited Judicial Review Determination***
The Moses H. Cone Memorial Hospital (Prov. No. 34-0091)
FYEs 9/30/2006, 9/30/2007, 9/30/2008, 9/30/2009, 9/30/2010, 9/30/2011
Case Nos. 13-1629, 19-2721, 19-2766, 20-0003, 20-0004, 20-0010

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the requests for expedited judicial review ("EJR") for the six (6) appeals referenced above involving The Moses H. Cone Memorial Hospital ("Provider"). Each of these EJRs was received on February 11, 2020. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue for which EJR has been requested in these appeals is:

> [W]hether Medicare Part C patients are "entitled to benefits" under Part A such that they should be counted in the Medicare Part A/Supplemental Security Income ("SSI") fraction [of the disproportionate share hospital adjustment] and excluded from the Medicaid fraction numerator or vice-versa.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

> 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*

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

> *part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[11]

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

[19] 69 Fed. Reg. at 49099.

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[24] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[26] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare

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[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] 72 Fed. Reg. at 47411.
[23] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).

fraction had been vacated in *Allina I*.[27] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[28] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[29]

In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[30] The Provider points out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

Decision of the Board

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

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[27] *Id.* at 943.
[28] *Id.* at 943-945.
[29] 69 Fed. Reg. at 49,099.
[30] *Allina* at 1109.

Jurisdiction

The participant that comprises these appeals within this EJR request have filed appeals involving fiscal years 2006-2011.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen*.[31] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[32]

On August 21, 2008, new regulations governing the Board were effective.[33] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[34] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[35]

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

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[31] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[32] *Bethesda at 1258-59.*
[33] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[34] 201 F. Supp. 3d 131 (D.D.C. 2016)
[35] *Banner* at 142.

However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that the participant involved with the instant EJR requests and which filed from original NPRs are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R as the Provider is challenging a regulation. In addition, the participant's documentation shows that the estimated amount in controversy for each individual appeal exceeds $10,000, as required for an appeal.[36] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction over the above-captioned appeals and the underlying provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the cost reporting periods 2006-2011. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time periods at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[37] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Provider would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[38]

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the participant in these individual appeals is entitled to a hearing before the Board;

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

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

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[36] *See* 42 C.F.R. § 405.1835.
[37] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[38] *See* 42 U.S.C. § 1395oo(f)(1).

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's requests for EJR for the issue and the subject years. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Case Nos. 19-2721, 19-2766, 20-0003, 20-0004 and 20-0010 will remain open since there are additional issue under appeal in those cases. As the Part C Days issue is the only issue remaining under dispute in Case No. 13-1629, the Board hereby closes Case No. 13-1629.

Board Members Participating:

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

FOR THE BOARD:

3/9/2020

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Laurie Polson, Palmetto GBA c/o NGS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Laurence D. Getzoff, Esq.
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Los Angeles, CA 90067-2517

RE: **EJR Determination**
14-2185GC Prospect 2009 DSH Medicaid Dual Eligible Part C Days Group
15-0091GC Prospect 2010 DSH Medicaid Dual Eligible Part C Days Group
14-4035GC Prospect 2011 DSH Medicaid Dual Eligible Part C Days Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 20, 2020 request for expedited judicial review ("EJR") for the three (3) CIRP group appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> [W]hether the Providers' DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

> 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*

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

> *part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[11]

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[24] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[26] the D.C. Circuit confirmed that

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[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] 72 Fed. Reg. at 47411.
[23] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).

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

Providers' Request for EJR

The Providers believe that by virtue of the statute, Medicare Part C days should not be included in either the numerator or denominator of the Medicare/SSI fraction. The Providers point out that in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), hospital inpatients who are "entitled to benefits under Part A" are to be included in the Medicare/SSI fraction, with all such patients in the denominator and those who are also entitled to SSI in the numerator. Patients enrolled in a Medicare Part C plan may be "eligible" for Part A, but are not "entitled" to Part A benefits during the months when they have given up their Part A entitlement to enroll in Part C. As a result, the Providers assert, inpatient days associated with these patients do not belong in the Medicare/SSI fraction.

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal because the Providers' appeal was timely filed and the $50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the 2004 rule [codified in the 2005 regulation at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B)].

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2009, 2010 and 2011.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of

[27] *Id.* at 943.
[28] *Id.* at 943-945.

Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[29] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[30]

On August 21, 2008, new regulations governing the Board were effective.[31] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[32] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[33]

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

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

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[29] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[30] *Bethesda*, 108 S. Ct. at 1258-59.
[31] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[32] 201 F. Supp. 3d 131 (D.D.C. 2016).
[33] *Id.* at 142.
[34] *See* 42 C.F.R. § 405.1837.

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

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2009, 2010 and 2011 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[35] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[36] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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

Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes those cases.

Board Members Participating:

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

FOR THE BOARD:

3/9/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Lorraine Frewert, Noridian
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

John R. Jacobs, Esq.
Akin Gump Straus Hauer & Feld LLP
2001 K Street, NW
Washington, DC 20026

RE: ***Expedited Judicial Review Determination***
Barnabas Health 2013 DSH SSI Fraction Part C Days Group
Case No. 16-2477GC

Dear Mr. Jacobs:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' January 23, 2020 request for expedited judicial review ("EJR") (received January 24, 2020) for the appeal referenced above.[1] In addition, the Board has considered the Providers' February 20, 2020 response (received February 24, 2020) to the Board's February 19, 2020 letter asking the Group Representative to confirm whether Case No. 16-2477GC should be bifurcated in order to place the period 10/1/2013-12/13/2013 in a separate case. The Group Representative responded by stating that this appeal involves ***only*** the periods *prior to* October 1, 2013. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in this appeal is:

> Whether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI[2] fraction and excluded from the Medicaid fraction numerator or vise-versa.[3]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] This request for EJR also included 11 other cases (Case Nos. 14-1925GC, *et al)* for the fiscal years 2006 through 2012 where the last period involving Case No. 16-2478GC. The Board issued a decision with respect to EJR in those cases on February 20, 2020.
[2] "SSI" is the acronym for "Supplemental Security Income."
[3] Providers' EJR Request at 4.

prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[6] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] 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.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] 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 . . . .[11]

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.[12]

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

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[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

> assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[13]

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.[14]

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [19]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[20]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[21] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are

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[17] *Id.*

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

[19] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[20] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[21] 69 Fed. Reg. at 49099.

> *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[22]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.[23] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[24] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[25]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[26] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[27] However, the Secretary has not acquiesced to that decision.

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[22] *Id.* (emphasis added).
[23] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[24] 72 Fed. Reg. at 47411.
[25] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[26] 746 F. 3d 1102 (D.C. Cir. 2014).
[27] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

More recently, in *Allina Health Services v. Price* ("*Allina II*"),[28] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[29] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[30] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[31]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[32] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

Decision of the Board

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

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

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2013 (prior to 10/1/2013).

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen*.[33] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[34]

On August 21, 2008, new regulations governing the Board were effective.[35] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[36] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[37]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left

[33] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[34] *Bethesda* at 1258-59.
[35] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[36] 201 F. Supp. 3d 131 (D.D.C. 2016)
[37] *Banner* at 142.

it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R as they are challenging a regulation. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[38] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction over the above-captioned appeals and the underlying, providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the cost reporting periods 2013, but ***only*** those portions prior to October 1, 2013. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time periods at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[39] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Provider would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[40] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2010) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

3/9/2020

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Bruce Snyder, Novitas Solutions
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Delivery

Laurence D. Getzoff, Esq.
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RE: ***EJR Determination***

13-2738GC	Community Med. Ctrs. 2008 DSH Medical Dual Eligible Days Part C Days Grp
13-3774GC	Community Med. Ctrs. 2009 DSH Medical Dual Eligible Part C Days Group
14-2340GC	Community Med. Ctrs. 2010 DSH Medical Dual Eligible Part C Days Group
15-2228GC	Community Med. Ctrs. 2011 DSH Medical Dual Eligible Part C Days Group
15-2413GC	CMC 2012 DSH Medical Dual Eligible Part C Days Group
16-1393GC	CMC 2013 DSH Medical Dual Eligible Part C Days Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 20, 2020 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> [W]hether the Providers' DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

> 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.[11]

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

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

Medicare Advantage Program

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

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

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

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

With the creation of Medicare Part C in 1997,[16] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services.
[14] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[15] *Id.*
[16] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [17]

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

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

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

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20]

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

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

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

[19] 69 Fed. Reg. at 49099.

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[24] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[26] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[27] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[28] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

The Providers believe that by virtue of the statute, Medicare Part C days should not be included in either the numerator or denominator of the Medicare/SSI fraction. The Providers point out

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[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] 72 Fed. Reg. at 47411.
[23] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.

that in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), hospital inpatients who are "entitled to benefits under Part A" are to be included in the Medicare/SSI fraction, with all such patients in the denominator and those who are also entitled to SSI in the numerator. Patients enrolled in a Medicare Part C plan may be "eligible" for Part A, but are not "entitled" to Part A benefits during the months when they have given up their Part A entitlement to enroll in Part C. As a result, the Providers assert, inpatient days associated with these patients do not belong in the Medicare/SSI fraction.

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal because the Providers' appeal was timely filed and the $50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the FFY 2005 IPPS final rule [later codified in the regulations at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B)].

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2008-2013.[29]

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[30] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[31]

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[29] Case No. 16-1403GC contains two providers, both with fiscal years ending August 31, 2013.
[30] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[31] *Bethesda*, 108 S. Ct. at 1258-59.

On August 21, 2008, new regulations governing the Board were effective.[32] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[33] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[34]

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[35] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

A. Appeals of Revised Notices of Program Reimbursement (NPRs) by Clovis Community Medical Center in Case Nos. 13-2738GC and 13-3774GC

Clovis Community Medical Center, Provider No. 05-0492 ("Clovis"), appealed revised NPRs as participant #2 in Case No. 13-2738GC (appealing FYE 8/31/2008) and as participant #1 in Case No. 13-2774GC (appealing FYE 8/31/2009). However, in each case, Clovis failed to document that dual eligible Medicaid/Part C days were adjusted as required for Board jurisdiction.

With respect to appeals of revised NPRs, the regulation, 42 C.F.R. § 405.1889 (2008), states that:

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

[32] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[33] 201 F. Supp. 3d 131 (D.D.C. 2016).
[34] *Id.* at 142.
[35] See 42 C.F.R. § 405.1889(b)(1) (2008).

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

In the above reference appeals, Clovis appealed revised NPRs that were the result of the Provider notifying the MAC that Clovis had included "Dual Eligible" days on the cost report in the Medicaid fraction, and that those days would have also been included in the SSI fraction. They were self-reporting that those days needed to be removed from the Medicaid fraction (more specifically, removal of 495 such days in FY 2008 and 113 such days in FY 2009). The description of the request to reopen does not state whether these "dual eligible" days were Medicaid/Medicare Part A or Medicaid/Medicare Part C dual eligible days. This description does reference CMS-1498-R (which is Dual eligible Medicaid/Medicare Part A) as well as "*Allina Hospitals v. Kathleen Sebelius"* and the 2004 rulemaking being vacated regarding Part C days. However, these are presumably identifiable specific patient days since, per 42 C.F.R. § 405.106(b)(4)(iii) "[t]he hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed" as part of the Medicaid fraction and, as such, generally will prepare a listing of days being claimed in anticipation of the cost report audit process. However, the description itself is not clear what type or category of Dual Eligible days was revised as part of the revised NPRs for FYs 2008 and 2009 and Clovis has not supplied any clarifying documentation. Further, for FY 2009, the revised NPR removed nonallowable Medicaid days from the DSH reimbursement but did not adjust the SSI fraction and, for 2008, the revised NPR removed certain dual eligible days from the Medicaid fraction to reconcile to the Provider's support and reopening request but did not adjust the SSI fraction.

Since Clovis failed to document that the *revised* NPRs for FYs 2008 and 2009 were specifically adjusted for the Dual Eligible Medicaid/ Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that is lacks jurisdiction over the revised NPRs and hereby dismisses Clovis' appeals of the revised NPRs for FYs 2008 and 2009. Because jurisdiction over a provider is a requisite to granting a request for EJR, the Board hereby denies the Clovis' request for EJR as it relates to the revised NPRs in Case Nos. 13-2738G and 13-3774GC.[36] The Board notes that, in Case Nos. 13-2738G and 13-3774GC, Clovis also has original NPR appeals and, as such, Clovis will continue to participate in these cases based on the original NPR appeals for FYs 2008 and 2009.

[36] *See* 42 C.F.R. § 405.1842(a).

B. Jurisdiction and EJR for the Remaining Participants

The Board has determined that all of the remaining participants involved with the instant EJR filed appeals from original NPRs and the requests are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[37] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals of original NPRs and the associated underlying remaining providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2008-2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[38] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[39] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter from the original NPR's, for the subject years and that the remaining participants in these group appeals are entitled to a hearing before the Board;

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the remaining Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes those cases.

Board Members Participating:

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

FOR THE BOARD:

3/11/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Lorraine Frewert, Noridian Health Care Solutions c/o Cahaba Safeguard Administrators
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Jordan Keville
Davis Wright Tremaine LLP
865 S. Figueroa Street, Suite 2400
Los Angeles, CA 90017

RE: ***Part C Days Medicaid and Medicare Proxy – EJR Determination***
Cedars - Sinai Medical Center (Prov. No. 05-0625)
FYE 06/30/2006, 06/30/2007, 06/30/2008, 06/30/2009
Case Nos. 17-0733, 13-3503, 15-2599, 16-2292

Dear Mr. Keville:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced appeal and, on December 12, 2019, as required by 42 C.F.R. § 405.1842(c), notified the Provider that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above referenced cases. The Provider, as well as, Federal Specialized Services ("FFS"), on behalf of the Medicare Contractor, has submitted comments as to whether the Board is without the authority to decide the following legal question[1]:

> CMS has included Part C/Medicare Advantage days in the SSI Medicare Fraction applied to the Provider… in accordance with a policy that CMS instituted without a formal rulemaking in 2004 and a formal rulemaking issued in 2007. Both of these policies changed CMS's prior policy of excluding Part C days from the SSI Medicare fraction…. The Provider seeks exclusion of the Part C/Medicare Advantage days from the SSI Medicare Fraction.[2]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] The Provider and FSS filed their responses to the Board on January 7, 2020, and January 13, respectively.
[2] Request for Hearing, Issue Statement, at Ex. 3 (Sep. 12, 2013), 13-3503; *See also* 15-2599, 16-2292, 17-0733.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*

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

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

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[10]

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

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

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

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

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

Medicare Advantage Program

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

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

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

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

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.
[15] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[16] *Id.*
[17] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[18]

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

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

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

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

Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

[18] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

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

[20] 69 Fed. Reg. at 49099.

> *with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[21]

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

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

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

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

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] *Id*. at 47411.
[24] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F. 3d 1102 (D.C. Cir. 2014).
[26] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[27] 863 F.3d 937 (D.C. Cir. 2017).
[28] *Id.* at 943.
[29] *Id.* at 943-945.

Board's Own Motion EJR

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

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

Decision of the Board

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

Jurisdiction

The Provider addressed in this EJR determination has filed appeals involving fiscal years 2006 through 2009.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[32] In that case, the Supreme Court concluded that a cost report submitted in

[30] 69 Fed. Reg. at 49,099.
[31] *Allina* at 1109.
[32] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[33]

On August 21, 2008, new regulations governing the Board were effective.[34] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[35] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[36]

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

The Board has determined that the Provider's appeals are governed by the decision in *Bethesda* and CMS-1727R as the Provider is challenging a regulation. The Provider appealed from original NPRs, the estimated amount in controversy exceeds $10,000, as required for an individual appeal[37] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the Provider in the referenced appeals.

Board's Analysis Regarding the Appealed Issue

The appeals in these cases involve the 2006 through 2009 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's

[33] *Bethesda*, 108 S. Ct. at 1258-59.
[34] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[35] 201 F. Supp. 3d 131 (D.D.C. 2016)
[36] *Id.* at 142.
[37] *See* 42 C.F.R. § 405.1837.

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

Board's Decision Regarding the EJR

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the Provider in the individual appeals 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)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the EJR for the issue and the subject years. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Case Nos. 13-1503, 15-2599 and 17-0733 have no issues remaining, and are now closed. Case No. 16-2292 has two issues remaining (related to organ acquisition cost) and will remain open.

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

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For the Board:

3/11/2020

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination***
CHS FFY 2020 Section 401 Hospitals Rural Floor Group
Case No. 20-1067GC

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 10, 2020 request for expedited judicial review ("EJR") for the above-referenced common issue related party ("CIRP") group appeal. The decision of the Board is set forth below.

The issue for which EJR has been requested involves:

> The Providers . . .challeng[e] [the Secretary's[1]] formula for the calculation of the rural floor, and specifically [the Secretary's] decision, announced in the Final IPPS [inpatient prospective payment system] Rule for 2020, not to treat Section 401 hospitals as being located in [] rural areas for [the] purpose of the rural floor calculation, and to assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state.[2]

Statutory and Regulatory Background

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[3] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs").

[1] of the Department of Health and Human Services.
[2] Providers' unpaginated EJR request, Section C (the Board lacks Authority to Decide the Legal Question at Issue and EJR Should Be Granted).
[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

The base payment rate is comprised of a standardized amount[4] for all subsection (d) hospitals located in an "urban" or "rural" area.[5]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary adjust the standardized amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.[6] The Secretary currently defines hospital labor market areas based on the delineations of statistical areas established by the Office of Management and Budget ("OMB").[7] Further, 42 U.S.C. § 1395ww(d)(3)(E) requires the Secretary to update the wage index annually and to base the update on a survey of wages and wage related costs of short-term, acute care hospitals.[8] The Secretary also takes into account the geographic reclassification of hospitals in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10) when calculating IPPS payment amounts.[9]

A. Wage Index

1. Rural Floor Adjustment

A hospital's wage index is the wage index the Secretary assigns to a specific geographical area where the hospital is located. Hospitals located in rural areas receive a wage index that applies to all rural areas in their state. Hospitals located in urban areas are grouped and treated as a single labor market based on a Core Based Statistical Area ("CBSA") in which they are physically located. Higher wage indices reflect higher labor costs in relation to the national average and, as a result, correspond to higher reimbursement rates.[10]

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in some urban hospitals being paid less than the average rural hospital in the state.[11] To correct this problem, in § 4410(a) of the Balanced Budget Act of 1997 ("BBA"),

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[4] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww (d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (August 18, 2006).
[5] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[6] 42 U.S.C. § 1395ww(d)3)(E).
[7] *See* 84 Fed. Reg. at 42300. The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. Under 42 U.S.C. § 1395ww(d)(3)(E) beginning with FY 2005, the Secretary delineated hospital labor market areas based on OMB-established Core-Based Statistical Areas ("CBSAs"). The current statistical areas (which were implemented beginning with FY 2015) are based on revised OMB delineations issued on February 28, 2013. Bulletin No. 13–01.
[8] 84 Fed.Reg. at 42300.
[9] *Id.*
[10] *Geisinger Community Med. Ctr. v. Secretary of DHHS*, 794 F. 3d 383, 386 (3d Cir. 2015).
[11] H.R. Rep. No. 105-149, at 1305 (1997).

Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state.[12] Specifically, BBA § 4410(a) states:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[13]

This provision is commonly referred to as the "rural floor."

2. Geographic Reclassification and "Section 401" Hospitals

In 1999, Congress recognized that, in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, Congress amended the Medicare Act to allow a hospital to seek reclassification from its geographical-based wage area to a nearby area for payment purposes if it met certain criteria and established the Medicare Geographic Review Board ("MGCRB") to administer the reclassification process.[14,15]

Ten years after the MGCRB was established, Congress enacted Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA").[16] BBRA § 401 instructed the Secretary to treat urban hospitals that applied to the MGCRB for redesignation as rural to be treated as such. Hospitals that receive these redesignations are sometimes known as "Section 401" hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

> (i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary ***shall treat the hospital as being located in the rural area*** (as defined in paragraph (2)(D)) of the State in which the hospital is located.
>
> (ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban

[12] Pub. L. 105-33, § 4410(a), 111 Stat. 251, 402 (1997) (uncodified as 42 U.S.C. § 1395ww note).
[13] *Id.*
[14] *Robert Wood Johnson Univ. Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002)
[15] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[16] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999) (codified as 42 U.S.C. § 1395ww(d)(8)).

> area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:
>
> (I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).
>
> (II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).
>
> (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
> (IV) The hospital meets such other criteria as the Secretary may specify.[17]

In the Conference Report accompanying BBRA § 401, Congress noted that:

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and rural referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospital as rural and entitled to the exceptions extended to referral centers and sole community hospital's if such hospitals are so designated.[18]

The Secretary codified regulations at 42 C.F.R. § 412.103 to implement BBRA § 401.[19] This regulation is entitled "Special treatment: Hospitals located in urban areas and that apply for reclassification."

B. Request for Comments in the Federal fiscal year ("FFY") 2019 IPPS Proposed Rule

In the FFY 2019 IPPS proposed Rule published on May 7, 2018,[20] the Secretary noted that there had been numerous studies, analyses and reports identifying disparities between the wage index values for individual hospitals and wage index values among different geographic areas and ways to improve the Medicare wage index, as well as public comments made during prior rulemaking.[21] The Secretary explained that the current wage index methodology relies on labor

[17] *Id.* (emphasis added).
[18] H.R. Conf. Rep. No. 106-479, 512 (1999).
[19] 65 Fed. Reg. 47026, 47031, 47048 (Aug. 1, 2000).
[20] 83 Fed. Reg. 20164 (May 7, 2018).
[21] *Id.* at 20372. For a discussion of those studies and references to previous requests for comments in the Federal Register, *see* 83 Fed. Reg. at 20372-76.

markets that are based on statistical area definitions (core-based statistical areas ("CBSAs")) established by OMB. Hospitals are grouped in either an urban labor market (that is a metropolitan statistical area ("MSA") or metropolitan division) or a statewide rural labor market (any area of a State that is not defined as urban). The current system relies on hospital data submitted to CMS, rather than data reflecting broader labor market wages such as data from the Bureau of Labor Statistics.[22]

In prior responses to earlier requests for comments, parties had complained that the current labor market definitions and wage data sources used by the Secretary, in many instances, are not reflective of the true cost of labor for any given hospital or are inappropriate to use for this purpose or both.[23] The Secretary noted that with respect to the labor market definitions, multiple exceptions and adjustments (for example, provider reclassifications under the MGCRB and the rural floor adjustment) have been put into place in attempts to correct perceived inequities. However, the Secretary pointed out, many of these exceptions and adjustments may create or further exacerbate distortions in labor market values. The issue of "cliffs," or significant differences in wage index values between proximate hospitals, can often be attributed to one hospital benefiting from such an exception and adjustment when another hospital cannot. With respect to the wage data sources, in public comments on prior proposed rulemakings cited earlier, many stakeholders have argued that the use of hospital reported data results in increasing wage index disparities over time between high wage index areas and low wage index areas.[24]

In light of the time that had elapsed from the previous studies, reports and earlier stakeholder comments regarding the wage index values for individual hospitals, the wage index values among different geographical areas and way to improve the Medicare wage index, the Secretary specifically solicited, as part of the FFY 2019 IPPS proposed rule, public comments on the wage index, as well as suggestions and recommendations for regulatory and policy changes to the Medicare wage index.[25]

C. Secretary's Discussion in the FFY 2020 Final IPPS Rule of the Responses to the Secretary's 2019 Request for Comments on the Rural Floor

In the FFY 2020 IPPS final rule published on August 15, 2019, the Secretary finalized several changes to the hospital wage index.[26] The Secretary noted that many responses had been received as a result of the FFY 2018 IPPS proposed rule's request for comments from stakeholders regarding the wage index. Those responses reflected common concerns that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals. In addition, respondents also expressed concern that the calculation of the rural floor has allowed a limited number of States to manipulate the wage index system to

[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.* at 20377.
[26] The Secretary announced the proposed changes in the FFY IPPS proposed rule published on May 7, 2019. 84 Fed Reg. 19158, 19396-98 (May 3, 2019)

achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities.[27]

In the final rule, the Secretary proposed several policies to address wage index disparities.[28] Relevant to the issue under appeal here are the Secretary's policies to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[29,30] The Secretary finalized without modification the following policies:

> ·to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . . [42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103); and
>
> ·for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of ''the wage index for rural areas in the State in which the county is located'' referred to in section [1395ww](d)(8)(C)(iii). . . .[31]

Notwithstanding his adoption of these policies, the Secretary did not codify them into the Code of Federal Regulations.

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[27] 84 Fed. Reg. 42044, 42325 (Aug. 16, 2019).
[28] *See generally id.* at 42336-42339.
[29] 42 C.F.R. § 412.103 states in relevant part that:

> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, ...
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.
>
> *****
>
> (7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

[30] *Id.*; 84 Fed. Reg. at 42332.
[31] 84 Fed Reg. at 42336.

1. *Removal of Urban to Rural Reclassification from the Calculation of the Rural Floor*

In the FFY 2020 IPPS proposed rule,[32] the Secretary had announced his proposal to remove urban reclassifications from the calculation of the rural floor under 42 U.S.C. § 1395ww(d)(8)(E) (as implemented by 42 C.F.R. § 412.103). In the FY 2020 IPPS final rule, the Secretary implemented that proposal stating that he believes that the proposed calculation methodology is permissible under the 42 U.S.C. § 1395ww(d)(8)(E) and BBA § 4410(a) which established the rural floor. The Secretary maintains that § 1395ww(d)(8)(E) does not specify where the wage data of reclassified hospitals must be included. Therefore, the Secretary believes that he has the discretion to exclude wage data of reclassified hospitals calculation of the rural floor. Furthermore, the Secretary explained that BBA § 4410(a) does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation. Therefore, the Secretary believes that he has the discretion BBA § 4410(a) to exclude the wage data of hospitals reclassified under § 1395ww(d)(8)(E) from the calculation of the rural floor.[33]

The Secretary contends that this policy is necessary and appropriate to address the unanticipated effects of rural floor reclassification on the rural floor and resulting wage index disparities, including the alleged manipulation of the rural floor by certain hospitals. The Secretary concludes that the inclusion of reclassified hospitals in the rural floor calculation has been an unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals.

2. *Removal of Urban to Rural Reclassifications from the Calculation of the Rural Floor Wage Index*

Pursuant to the FFY 2020 IPPS final rule, the Secretary would continue to calculate the rural floor based on the physical non-MSA area of the state, which is the same rural area to which a hospital is reclassified under § 1395ww(d)(8)(E). However, for purposes of calculating the rural floor wage index for a state, the Secretary would not include in the rural area the data of hospitals that have been reclassified as rural under § 1395ww(d)(8)(E). The Secretary pointed out that the legislative intent of the rural floor was to correct the anomaly of some urban hospitals being paid less than the average rural hospital in their States.[34]

The Secretary had found that, under the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural. The Secretary explained that while urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification, other states with high wage urban hospitals using 42 C.F.R. § 412.103 reclassification to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality. The Secretary believes that, excluding the data of hospitals that

[32] 84 Fed Reg. 19158, 19396-8 (May 3, 2019).
[33] 84 Fed. Reg. *at* 42333.
[34] *Id.* at 42334.

reclassify as rural under § 1395ww(d)(8)(E) from the rural floor wage index is necessary and appropriate to address the unanticipated effects of the rural floor reclassifications on the rural floor and the resulting wage index disparities.[35]

The Secretary contends that his reimbursement calculation is permissible under 42 U.S.C. § 1395ww(d)(8)(E) (as implemented by 42 C.F.R. § 412.103) and BBA § 4410(a)). The statute does not specify where the wage data of reclassified hospitals must be included. Therefore, the Secretary believes that he has the discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. In addition, the Secretary points out, BBA § 4410(a) does not specify how the rural floor wage index is to be calculated or what data is to be included in the calculation. Consequently, the Secretary believes that he has the discretion under BBA § 4410(a) to exclude the wage data of hospitals reclassified under § 1395ww(d)(8)(E) from the calculation of the rural floor.[36]

Providers' Position

The Providers explain that Section 401 hospitals must be treated as being located in a rural area for all purposes pursuant to 42 U.S.C. § 1395ww(d)(8)(E). As a result, no urban hospital can be assigned a wage index lower than the wage index assigned to rural hospitals in the same state (known as the rural floor adjustment).[37] In the FFY 2020 IPPS final rule, the Providers contend that the Secretary announced a new rule that would violate both requirements: (1) Section 401 hospitals would not be treated as rural in calculating the rural floor; and (2) urban hospitals would be assigned a lower wage index than the one applicable to rural hospitals in the same state. The Providers contend that the new wage index rule is unlawful because it conflicts with the requirements of the Medicare statute.

The Providers object to the Secretary's decision " to calculate the rural floor without including the wage index data of urban hospitals reclassified as rural under [42 U.S.C. § 1395ww(d)(8)(e)] (as implemented by 42 C.F.R. § 412.103)." In addition, the Secretary would not treat Section 401 hospitals as being located in a rural area in a state for purposes of determining the rural floor wage index. The Providers assert that the Secretary has assigned wage index values to urban hospitals that are lower than the wage index values of rural hospitals in the same state. The Providers contend that for purposes of calculating IPPS payment for FFY 2020, the Secretary will calculate the rural floor in a state without reference to the wage index that applies for any Section 401 hospital in that state.

The Providers argue that the Secretary's decision to exclude Section 401 hospitals from his rural floor calculations has no basis in the text of the statute. Rather, 42 U.S.C. § 1395ww(d)(8)(E) requires that, for purposes of the IPPS statue, the Secretary "shall treat" a qualifying hospital "as being located in the rural area. . .of the State in which the hospital is located"[38] And BBA § 4410(a) specifies that the wage index for hospitals in a state "may not be less than the area

[35] *Id.*
[36] *Id.*
[37] BBA § 4410(a) (available at 42 U.S.C. § 1395oo note).
[38] 42 U.S.C. § 1395ww(d)(8)(E)(1).

wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located." The Providers assert that, contrary to the Secretary's characterization of these provisions in the rulemaking, neither provision leaves it to the Secretary's discretion as to whether he will comply with the terms of the statutes.

The Providers believe that the Secretary's interpretation is unlawful because it violates the statute and is not based on a reasonable interpretation of the statute. The Providers contend that EJR is appropriate because the Board has jurisdiction over the Providers' appeals but lacks the legal authority to find that the Secretary's calculation of the FFY 2020 rural floor is unlawful because the Secretary does not have the statutory authority to exclude data of Section 401 hospitals from the calculation of the rural floor and cannot assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state. Nor can the Board compel the Secretary to pay the Providers' reimbursement that it withheld as a result of that regulation.

Decision of the Board

The participants that comprise the group appeal within this EJR request have filed an appeal involving FFY 2020 based on their appeal from the FFY 2020 IPPS final rule.

A. Jurisdiction and Request for EJR

As previously noted, all of the participants appealed from the FFY 2020 IPPS final rule.[39] The Board has determined the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[40] The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Application of 42 C.F.R. § 405.1873

The Board notes that the *cost report periods* for the participants in this group appeal that are impacted by FFY 2020 IPPS final rule begin well after January 1, 2016 and, as such, are subject to the newly-added 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports.[41] However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether any Provider's cost report included an appropriate claim for the specific item under appeal, presumably because any such potential issue is not yet ripe. In this regard, the Board notes that the participants are appealing the FFY

[39] The CMS Administrator has determined that a Federal Register notice is a final determination from which a provider may appeal to the Board. *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*), rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015).
[40] *See* 42 C.F.R. § 405.1837.
[41] *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015).

2020 Federal Register Notice and the cost reports impacted by such notice have not yet been filed to trigger § 413.24(j)'s general substantive payment requirement for cost reports.[42]

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to treat Section 401 hospitals as not being located in a rural area for the purpose of the rural floor calculation and to assign a wage index to urban hospitals that was lower than the wage index assigned to rural hospitals was made through notice and comment in the form of an uncodified regulation.[43] Specifically, in the preamble to FFY 2020 IPPS final rule, the Secretary announced the following the modification to address wage index disparities:

> · to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . .(as implemented at § 412.103); and
>
> ·for purposes of applying the provisions of . . .[42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of ''the wage index for rural areas in the State in which the county is located'' referred to in section [1395ww](d)(8)(C)(iii). . . .[44]

The Secretary did ***not*** incorporate the above new policy setting forth a modification to the wage index calculation for the rural floor and to remove the wage data of urban hospitals reclassified as rural from the calculation of the wage index into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS final rule that the Secretary intended to bind the regulated parties and establish a binding *uniform* payment policy through formal notice and comment:

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E) . . . (as implemented at [42 C.F.R.] § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section § [1395ww](d)(8)(C)(iii) . . .to remove the wage data of urban hospitals reclassified as rural under section 1395ww](d)(8)(E). . .(as implemented at § 412.103) from the calculation of ''the wage

[42] *See* 80 Fed. Reg. at 70556, 70569-70.
[43] *See* 84 Fed. Reg. 42044, 42325-36 (section entitled "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals").
[44] *Id.* at 42336.

> index for rural areas in the State in which the county is located'' referred to in section [1395ww](d)(8)(C)(iii). . . .[45]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulation on Rural Reclassification." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[46]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to by the Uncodified Regulation on Rural Reclassification published in the FFY 2020 IPPS final rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on Rural Reclassification which they allege improperly removes the payment provisions established by Congress for rural floor calculation and the removal of the wage data urban hospitals reclassified as rural from the calculation of the wage index. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in this case.

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding the FFY 2020 IPPS final rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Uncodified Regulation on Rural Reclassification as published in the FFY 2020 IPPS final rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Rural Reclassification as published in the FFY 2020 IPPS final rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the

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[45] *Id.*

[46] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

3/11/2020

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Byron Lamprecht, WPS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Laurence D. Getzoff, Esq.
Hooper, Lundy and Bookman, P.C.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2517

RE: **EJR Determination**

13-2738GC	Community Med. Ctrs. 2008 DSH Medicaid Dual Eligible Days Part C Days Grp
13-3774GC	Community Med. Ctrs. 2009 DSH Medical Dual Eligible Part C Days Group
14-2341GC	Community Med. Ctrs. 2010 DSH Medical Dual Eligible Part C Days Group
15-2230GC	Community Med. Ctrs. 2011 DSH Medical Dual Eligible Part C Days Group
15-2414GC	CMC 2012 DSH Medicaid Dual Eligible Part C Days Group
16-1403GC	Community Med. Ctrs. 2013 Medical Dual Eligible Part C Days Group

Dear Mr. Getzoff,

On March 11, 2020, the Board issued a decision regarding Expedited Judicial Review ("EJR") in the above-referenced cases. The Board inadvertently included some incorrect case numbers and names in the "Re" line of the EJR determination. Notwithstanding these errors, the Board notes that the Schedules of Providers attached to the EJR determination did correctly reflect the correct groups that are part of the determination. To avoid confusion, the Board is re-issuing its EJR determination with the correct case names and numbers in the "Re" line of the EJR determination..

For the Board:

3/12/2020

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Admin

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Laurence D. Getzoff, Esq.
Hooper, Lundy and Bookman, P.C.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2517

RE: ***Corrected EJR Determination***

13-2738GC	Community Med. Ctrs. 2008 DSH Medicaid Dual Eligible Days Part C Days Grp
13-3774GC	Community Med. Ctrs. 2009 DSH Medicaid Dual Eligible Part C Days Group
14-2341GC	Community Med. Ctrs. 2010 DSH Medicaid Dual Eligible Part C Days Group
15-2230GC	Community Med. Ctrs. 2011 DSH Medicaid Dual Eligible Part C Days Group
15-2414GC	CMC 2012 DSH Medicaid Dual Eligible Part C Days Group
16-1403GC	Community Med. Ctrs. 2013 Medicaid Dual Eligible Part C Days Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 20, 2020 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> [W]hether the Providers' DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

> 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.[11]

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

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

Medicare Advantage Program

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

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

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

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

With the creation of Medicare Part C in 1997,[16] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services.
[14] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[15] *Id.*
[16] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [17]

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

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

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

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20]

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

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

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

[19] 69 Fed. Reg. at 49099.

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[24] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[26] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[27] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[28] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

The Providers believe that by virtue of the statute, Medicare Part C days should not be included in either the numerator or denominator of the Medicare/SSI fraction. The Providers point out

[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] 72 Fed. Reg. at 47411.
[23] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.

that in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), hospital inpatients who are "entitled to benefits under Part A" are to be included in the Medicare/SSI fraction, with all such patients in the denominator and those who are also entitled to SSI in the numerator. Patients enrolled in a Medicare Part C plan may be "eligible" for Part A, but are not "entitled" to Part A benefits during the months when they have given up their Part A entitlement to enroll in Part C. As a result, the Providers assert, inpatient days associated with these patients do not belong in the Medicare/SSI fraction.

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal because the Providers' appeal was timely filed and the $50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the FFY 2005 IPPS final rule [later codified in the regulations at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B)].

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2008-2013.[29]

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[30] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[31]

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[29] Case No. 16-1403GC contains two providers, both with fiscal years ending August 31, 2013.
[30] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[31] *Bethesda*, 108 S. Ct. at 1258-59.

On August 21, 2008, new regulations governing the Board were effective.[32] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[33] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[34]

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[35] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

A. Appeals of Revised Notices of Program Reimbursement (NPRs) by Clovis Community Medical Center in Case Nos. 13-2738GC and 13-3774GC

Clovis Community Medical Center, Provider No. 05-0492 ("Clovis"), appealed revised NPRs as participant #2 in Case No. 13-2738GC (appealing FYE 8/31/2008) and as participant #1 in Case No. 13-2774GC (appealing FYE 8/31/2009). However, in each case, Clovis failed to document that dual eligible Medicaid/Part C days were adjusted as required for Board jurisdiction.

With respect to appeals of revised NPRs, the regulation, 42 C.F.R. § 405.1889 (2008), states that:

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

[32] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[33] 201 F. Supp. 3d 131 (D.D.C. 2016).
[34] *Id.* at 142.
[35] See 42 C.F.R. § 405.1889(b)(1) (2008).

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

In the above reference appeals, Clovis appealed revised NPRs that were the result of the Provider notifying the MAC that Clovis had included "Dual Eligible" days on the cost report in the Medicaid fraction, and that those days would have also been included in the SSI fraction. They were self-reporting that those days needed to be removed from the Medicaid fraction (more specifically, removal of 495 such days in FY 2008 and 113 such days in FY 2009). The description of the request to reopen does not state whether these "dual eligible" days were Medicaid/Medicare Part A or Medicaid/Medicare Part C dual eligible days. This description does reference CMS-1498-R (which is Dual eligible Medicaid/Medicare Part A) as well as "*Allina Hospitals v. Kathleen Sebelius"* and the 2004 rulemaking being vacated regarding Part C days. However, these are presumably identifiable specific patient days since, per 42 C.F.R. § 405.106(b)(4)(iii) "[t]he hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed" as part of the Medicaid fraction and, as such, generally will prepare a listing of days being claimed in anticipation of the cost report audit process. However, the description itself is not clear what type or category of Dual Eligible days was revised as part of the revised NPRs for FYs 2008 and 2009 and Clovis has not supplied any clarifying documentation. Further, for FY 2009, the revised NPR removed nonallowable Medicaid days from the DSH reimbursement but did not adjust the SSI fraction and, for 2008, the revised NPR removed certain dual eligible days from the Medicaid fraction to reconcile to the Provider's support and reopening request but did not adjust the SSI fraction.

Since Clovis failed to document that the *revised* NPRs for FYs 2008 and 2009 were specifically adjusted for the Dual Eligible Medicaid/ Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that is lacks jurisdiction over the revised NPRs and hereby dismisses Clovis' appeals of the revised NPRs for FYs 2008 and 2009. Because jurisdiction over a provider is a requisite to granting a request for EJR, the Board hereby denies the Clovis' request for EJR as it relates to the revised NPRs in Case Nos. 13-2738G and 13-3774GC.[36] The Board notes that, in Case Nos. 13-2738G and 13-3774GC, Clovis also has original NPR appeals and, as such, Clovis will continue to participate in these cases based on the original NPR appeals for FYs 2008 and 2009.

[36] *See* 42 C.F.R. § 405.1842(a).

B. Jurisdiction and EJR for the Remaining Participants

The Board has determined that all of the remaining participants involved with the instant EJR filed appeals from original NPRs and the requests are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[37] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals of original NPRs and the associated underlying remaining providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2008-2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[38] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[39] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter from the original NPR's, for the subject years and that the remaining participants in these group appeals are entitled to a hearing before the Board;

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the remaining Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes those cases.

Board Members Participating:

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

FOR THE BOARD:

3/12/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Lorraine Frewert, Noridian Health Care Solutions c/o Cahaba Safeguard Administrators
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Laurence D. Getzoff, Esq.
Hooper, Lundy and Bookman, P.C.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2517

RE: ***EJR Determination***

13-1121GC	Integris Health 2007 DSH Medicaid Fraction Dual Eligible Part C Days
13-1122GC	Integris Health 2008 DSH Medicaid Fraction Dual Eligible Part C Days
14-0830GC	Integris Health 2009 DSH Medicaid Fraction Dual Eligible Part C Days

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 25, 2020 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> [W]hether the Providers' DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[4] These cases involve the hospital-specific DSH adjustment, which requires the

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

Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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

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

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

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

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

> 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.[11]

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[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] (Emphasis added.)
[10] 42 C.F.R. § 412.106(b)(2)-(3).
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The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[12]

Medicare Advantage Program

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

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

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

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

With the creation of Medicare Part C in 1997,[16] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services.
[14] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
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care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [17]

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

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

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

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

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Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

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

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

[19] 69 Fed. Reg. at 49099.

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20]

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[24] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[26] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[27] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[28] Once again, the Secretary has not acquiesced to this decision.

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[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] 72 Fed. Reg. at 47411.
[23] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.

Providers' Request for EJR

The Providers believe that by virtue of the statute, Medicare Part C days should not be included in either the numerator or denominator of the Medicare/SSI fraction. The Providers point out that in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), hospital inpatients who are "entitled to benefits under Part A" are to be included in the Medicare/SSI fraction, with all such patients in the denominator and those who are also entitled to SSI in the numerator. Patients enrolled in a Medicare Part C plan may be "eligible" for Part A, but are not "entitled" to Part A benefits during the months when they have given up their Part A entitlement to enroll in Part C. As a result, the Providers assert, inpatient days associated with these patients do not belong in the Medicare/SSI fraction.

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal because the Providers' appeal was timely filed and the $50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the 2004 rule [codified in the 2005 regulation at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B)].

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2007-2009.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[29] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the

[29] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[30]

On August 21, 2008, new regulations governing the Board were effective.[31] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[32] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[33]

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[34] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the for each of the participants involved with the instant EJR that filed appeals from original NPRs, the requests are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R because the Providers are challenging a regulations. The one participant which appealed a revised NPR had an adjustment to Part C days as required for Board jurisdiction pursuant to 42 C.F.R. § 405.1889. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for

[30] *Bethesda*, 108 S. Ct. at 1258-59.
[31] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[32] 201 F. Supp. 3d 131 (D.D.C. 2016).
[33] *Id*. at 142.
[34] See 42 C.F.R. § 405.1889(b)(1) (2008).

a group appeal.[35] The appeals were timely filed. Therefore, based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2007-2009 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[36] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[37] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

3/18/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Justin Lattimore Novitas Solutions
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Laurence D. Getzoff, Esq.
Hooper, Lundy and Bookman, P.C.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2517

RE: ***EJR Determination***
13-2743GC Maury Reg'l Med. Ctr. 2008 DSH Medicaid Dual Eligible Part C Days Group
14-2531GC Maury Reg'l Med. Ctr. 2010 DSH Medicaid Dual Eligible Part C Days Group
13-2745GC Alta Hosps. Sys. 2008 DSH Medicaid Dual Eligible Part C Days Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 25, 2020 requests for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> [W]hether the Providers' DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

The PPS statute contains a [4]number of provisions that adjust reimbursement based on hospital-specific factors.[5] These cases involve the hospital-specific DSH adjustment, which requires the

[1] Providers' EJR Request at 1.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4]
[5] *See* 42 U.S.C. § 1395ww(d)(5).

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

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

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

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

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

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]

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

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

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

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care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [18]

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

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

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

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

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Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

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> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[21]

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[25] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[26] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[28] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[29] Once again, the Secretary has not acquiesced to this decision.

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] 72 Fed. Reg. at 47411.
[24] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F. 3d 1102 (D.C. Cir. 2014).
[26] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[27] 863 F.3d 937 (D.C. Cir. 2017).
[28] *Id.* at 943.
[29] *Id.* at 943-945.

Providers' Request for EJR

The Providers believe that by virtue of the statute, Medicare Part C days should not be included in either the numerator or denominator of the Medicare/SSI fraction. The Providers point out that in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), hospital inpatients who are "entitled to benefits under Part A" are to be included in the Medicare/SSI fraction, with all such patients in the denominator and those who are also entitled to SSI in the numerator. Patients enrolled in a Medicare Part C plan may be "eligible" for Part A, but are not "entitled" to Part A benefits during the months when they have given up their Part A entitlement to enroll in Part C. As a result, the Providers assert, inpatient days associated with these patients do not belong in the Medicare/SSI fraction.

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal because the Providers' appeal was timely filed and the $50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the 2004 rule [codified in the 2005 regulation at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B)].

Decision of the Board

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

Jurisdiction

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

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[30] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the

[30] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[31]

On August 21, 2008, new regulations governing the Board were effective.[32] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[33] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[34]

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

The Board has determined that the all of the participants involved with the instant EJR filed appeals from original NPRs and the requests are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R because the providers are challenging a regulation. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[35] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals of original NPRs and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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[31] *Bethesda*, 108 S. Ct. at 1258-59.
[32] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[33] 201 F. Supp. 3d 131 (D.D.C. 2016).
[34] *Id.* at 142.
[35] *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2008 and 2010 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[36] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[37] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

3/18/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Cecile Huggins, Palmetto GBA
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Remand Order/Expedited Judicial Review***
North Arkansas Regional Medical Center, Prov. No. 04-0017, FYE 3/31/2011
Participant in Hall Render 2011 DSH SSI Fraction Dual Eligible Days Group II
Case No. 15-1672G

Dear Ms. Griffin:

Enclosed is the Provider Reimbursement Review Board's (Board) Notice of Reopening and Order issued pursuant to the Centers for Medicare & Medicaid Services' Administrator's Order issued in Case No. 15-1672G relating to the participant, North Arkansas Regional Medical Center for the fiscal year ending March 31, 2011. In addition, since the last request made in the group appeal was a request that the Board determine if expedited judicial review ("EJR") was appropriate for the issue under appeal, the Board is issuing its finding with respect to that open request for North Arkansas Regional Medical Center as well.

Sincerely,

3/18/2020

X Clayton J. Nix

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

Enclosures: Board's Notice of Reopening and Order
EJR Determination
Remand Order

cc: Cecile Huggins, Palmetto GBA
Wilson Leong, FSS
Jacqueline Vaughn, Esq., OAA

United States Department of Health and Human Services
Provider Reimbursement Review Board

North Arkansas Regional Medical Center (provider no. 04-0017) as a participant in Hall Render 2011 DSH SSI Fraction Dual Eligible Days Group II	*	PRRB Case No. 15-1672G
v.	*	
Novitas Solutions, Inc.	*	FY 2011

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Notice of Reopening Pursuant to the Administrator's
Order of Remand

and

Provider Reimbursement Review Board Order

I
Reopening

By ORDER dated February 4, 2020, the Principle Deputy Administrator of the Centers for Medicare & Medicaid Services (Deputy Administrator) remanded to the Provider Reimbursement Review Board (Board) North Arkansas Regional Medical (Provider No. 04-0017, FYE 3/31/2011) as a participant in the Hall Render 2011 DSH SSI Fraction Dual Eligible Days Group II, Case No. 15-1672G.

Background

On May 3, 2018, Hall, Render, Killian Health & Lyman filed a request that the Board grant expedited judicial review (EJR) for 21 group appeals involving the issue of:

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

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

As part of determining whether to grant a request for EJR, the regulations, 42 C.F.R. § 405.1842(b) and (f)(1)(i) require that the Board have jurisdiction over the matter at issue for each provider in a group appeal. Section 405.1842(f)(2) requires that the Board deny a request for EJR where Board determines that it lacks jurisdiction over the matter at issue for a provider in a group appeal.

In the case of North Arkansas Regional Medical Center, the Provider filed an appeal of a revised Notice of Program Reimbursement (NPR) dated October 9, 2014. The regulation, 42 C.F.R. § 405.1889, governs the appeal of a revised NPR and states that:

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

For any provider that files an appeal of a revised NPR after August 21, 2008, the regulation limits the Board's jurisdiction to matters the Medicare Contractor specifically revised. In the case of North Arkansas Regional Medical Center, the SSI issue that was the subject of the appeal was not adjusted as required by 42 C.F.R. § 405.1889.[2] Consequently, the Board concluded that lacked it jurisdiction over North Arkansas Regional Medical Center, dismissed the Provider from the appeal and denied the Provider's request for EJR. This finding was incorporated into the Board's June 1, 2018 decision regarding EJR for the 21 cases.

Subsequently, the Provider filed an appeal of this determination in the United States District Court for the District of Columbia ("Court").[3] During the course of the litigation, the parties

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[1] Providers' EJR Request at 2.
[2] *See* Provider's March 24, 2015 Request to Join an Existing Appeal, Tab 2. The audit adjustment report contained 5 adjustments. Adjustment 1, completed cost report forms and pages in accordance with current regulations; Adjustment 2 Correct mathematical and flow through errors in cost reporting forms; Adjustment 3 was made to determine whether total Program reimbursement costs exceeded total program charges; Adjustment 4 updated DSH allowable percentage; Adjustment 5 was made to properly include all last NPR payments.
[3] Civil Action No. 18-1795 (RDM).

entered into a settlement agreement in which the Secretary agreed that the jurisdictional dismissal and the denial of the Provider's request for EJR would be vacated and the Provider's case would be remanded to the Secretary for further proceedings before the Board.[4]

Administrator's Remand

On February 7, 2020, the Deputy Administrator remanded Case No. 15-1672G to the Board. In that remand, the Administrator ordered that:

> the [Board's] dismissal in the case of Hall Render 2011 DSH SSI Fraction Dual Eligible Days Group II, PRRB Case 15-1672G is hereby vacated with respective to the Provider's claims only (Provider No. 04-0017); and
>
> the [Board] shall, within 60 days of receiving this matter on remand, reopen PRRB Case No. 15-1672G as it relates to the Provider's disproportionate share hospital (DSH) claims for its fiscal year ending March 31, 2011; and
>
> the [Board], as set forth in paragraph 3 of the Settlement Agreement, ***shall exercise jurisdiction regarding the merits of the Provider's appeal*** of CMS' calculation of its DSH patient percentage and the resulting DSH payment adjustment for the fiscal year ending March 31, 2011; and
>
> the [Board] shall take actions consistent with the Settlement Agreement and Court Order in this case; and
>
> the decision of the Board is subject to the provisions of 42 C.F.R. § 405.1875.[5]

In compliance with the remand and order of the Deputy Administrator, the Board hereby reopens Case No. 15-1672G as it relates to North Arkansas Regional Medical Center's disproportionate share claims for the Provider's fiscal year ending March 31, 2011.

[4] Settlement Agreement in Civil Action No. 18-1795 (RDM) ¶ 1 at 3.
[5] (Emphasis added.)

II

Board Order

Pursuant to the Administrator's Remand, the Board is exercising its jurisdiction regarding the merits of North Arkansas Regional Medical's (Provider No. 04-0017) appeal of CMS' calculation of its DSH patient percentage and the resulting DSH payment adjustment for the fiscal year ending March 31, 2011. In conjunction with this jurisdictional finding, a decision with respect to EJR over the issue under dispute in Case No. 15-1672G with respect to North Arkansas Regional Medical Center is attached.

SO ORDERED by the
Provider Reimbursement Review Board

3/18/2020

X Clayton J. Nix

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

Attachments: Administrator's Remand Order
EJR Determination

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***EJR Determination Hall Render DSH Dual Eligible SSI Patient Days Groups***
North Arkansas Regional Medical Center, Prov. No. 04-0017, FYE 3/31/2011
Participant in the Hall Render 2011 DSH SSI Fraction Dual Eligible Days Group II
Case No. 15-1672G

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") was ordered by the Administrator of the Centers for Medicare & Medicaid Services to exercise jurisdiction over North Arkansas Regional Medical and issue a decision regarding the merits of the Provider's appeal incident to a settlement agreement in *North Arkansas Regional Medical Center v. Azar*.[6, 7] Incident to the Administrator Order, under separate cover, the Board has issued a Notice of Reopening and Order stating that it was reopening case number 15-1672G as it relates to North Arkansas Regional Medical Center's ("North Arkansas' ") disproportionate share claims and exercising jurisdiction over the merits of the Provider's appeal. Since the last action initiated by the Providers in the group appeal was a request for expedited judicial review ("EJR"), the Board is reviewing the original May 3, 2019 EJR request as it applies to North Arkansas. The Board's decision with respect to EJR for North Arkansas is set forth below.

Issue in Dispute

The issue for which the Board is considering EJR is:

> [W]hether the Provider's Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were

[6] Civil Action No. 18-1795 (RDM) (D.D.C. 2020).
[7] Order of the Administrator at 1.

> enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[8]

Medicare Disproportionate Share Hospital (DSH) Payment Background

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[9] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[10] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the "SSI fraction" or "SSI ratio") and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were entitled to benefits under part A of the subchapter and were entitled to supplementary security income benefits…under subchapter XVI of this chapter…"; and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

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

[8] Providers' EJR Request at 2.
[9] 42 C.F.R. Part 412.
[10] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).

> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[11]

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

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[12] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[13] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[14]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[15] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[16]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[17] and may terminate,[18] suspend[19] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[20] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

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[11] (Bold emphasis added and italics emphasis in original.)
[12] 42 U.S.C. § 1382.
[13] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[14] 20 C.F.R. § 416.202.
[15] 42 U.S.C. § 426.
[16] 42 U.S.C. § 426-1.
[17] 20 C.F.R. § 416.204.
[18] 20 C.F.R. §§ 416.1331-1335.
[19] 20 C.F.R. §§ 416.1320-1330.
[20] 20 C.F.R. § 1320.

1. The individual fails to give the SSA permission to contact financial institutions;[21]
2. The individual fails to apply for other benefits to which the individual may be entitled;[22]
3. The individual fails to participate in drug or alcohol addiction treatment;[23]
4. The individuals is absent from the United States for more than 30 days;[24] or
5. The individual becomes a resident of a public institutions or prison.[25]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[26]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[27] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[28] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[29] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[30] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[31]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the

[21] 20 C.F.R. § 416.207.
[22] 20 C.F.R. § 416.210.
[23] 20 C.F.R. § 416.214.
[24] 20 C.F.R. § 416.215.
[25] 20 C.F.R. § 416.211.
[26] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[27] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[28] *Id.*
[29] *Id.*
[30] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[31] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.

plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[32]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[33] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[34] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[35]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[36] The proposed rule includes references to

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

[33] CMS-1498-R at 5.

[34] *Id.*

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

[36] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[37]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[38] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[39] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[40] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[41] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[42]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[43] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the

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

[38] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

[39] *Id.* at 50280.

[40] *Id.* at 50280-50281.

[41] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.

[42] *Id.* at 50285.

[43] CMS-1498-R at 6-7, 31.

jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[44] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[45]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[46]

As a result of the Rulings, new regulation and data match process, CMS either calculated new SSI percentages or recalculated existing SSI percentages for each of the Providers for all of fiscal years at issue in these appeals.[47] All of the Providers in the groups covered by this EJR decision have appealed from *original* NPRs that used SSI percentages calculated based on the methodology articulated in the preamble to the FY 2011 IPPS Final Rule which includes using only the three SSI codes to denote SSI entitlement under 42 C.F.R. § 412.106(b)(2).

Provider's Request for EJR

The Provider asserts that under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Provider points out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Provider explains that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from SSA for the month in question. The Provider contends that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[48]

The Provider notes that in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[49] Thus, the

[44] *Id.* at 28, 31.
[45] 75 Fed. Reg. at 24006.
[46] CMS-1498-R2 at 2, 6.
[47] The SSI ratios for FY 2009 and 2010 were published on March 16, 2012 and October 17, 2012, respectively. *See* https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[48] 75 Fed. Reg. at 50,275-286.
[49] *Id.* at 50,281.

Provider alleges the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Provider believes that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Provider asserts in its request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the Medicare statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' DPP calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act.[50]

Decision of the Board

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

A. Jurisdictional Determination

The IPPS/DSH participant, North Arkansas Regional Medical Center that comprise the appeal within this EJR request have filed an appeal involving fiscal year 2011.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending *prior to December 31, 2008*, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[51] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[52]

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[50] Pub. L. No. 108-173, § 951, 117 Stat. 2066, 2427 (2003).
[51] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[52] *Bethesda* at 1258-59.

On August 21, 2008, new regulations governing the Board were effective.[53] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[54] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[55]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R ("Ruling 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under Ruling 1727-R, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest. The Board finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. Consequently, consistent with the Administrator's Remand Order, the Board finds that it has jurisdiction over the remaining IPPS/DSH Provider in this case.

B. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued Ruling 1498-R on April 28, 2010 to authorize remands of pending appeals of the SSI data match issue in order to recalculate the associated SSI fractions based on a revised data match process.[56] The Secretary also stated in the Ruling that, for those hospitals whose cost reports had not yet been settled, the Secretary would recalculate the SSI fractions for those cost reports using the revised data match process to be published through rulemaking.[57]

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[53] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[54] 201 F. Supp. 3d 131 (D.D.C. 2016)
[55] *Banner* at 142.
[56] CMS Ruling 1498-R at 27.
[57] *Id.* at 31.

Contemporaneous with Ruling 1498-R,[58] the Secretary published a proposed IPPS rule[59] to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the FY 2011 IPPS Final Rule in which the Secretary explained that:

> . . .we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[60]

Then she further announced:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[61]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[62]

While the Secretary did not incorporate the above new policy involving the revised data match process directly into the Code of Federal Regulations, it is clear from the language in the preamble to the FY 2011 IPPS Final Rule, as set forth above, that the Secretary intended to bind

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[58] *Id.* at 5.
[59] 75 Fed. Reg. 23852, 24002-07.
[60] 75 Fed. Reg. at 50277.
[61] (Medicare) Enrollment Database.
[62] 75 Fed. Reg. at 50285.

the regulated parties and establish a binding data match process to be used by CMS in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2).

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[63] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation the published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the IPPS/DSH Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility.[64] As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this case for North Arkansas Regional Medical Center.

C. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the North Arkansas Regional Medical Center as a participant in this group appeal is entitled to a hearing before the Board;

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

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

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[63] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

[64] The Board notes that North Arkansas appeal period begins prior to 10/1/2011 and has *only* disputed the validity of the Uncodified SSI Data Matching Regulation which was finalized in the FY 2011 IPPS Final Rule and is applied to it via Ruling 1498-R as confirmed in the preamble to the FY 2011 IPPS Final Rule (75 Fed. Reg. at 50824-25) and has ***not*** raised any disputes or issues regarding the validity of Ruling 1498-R itself. Accordingly, the Board finds that there are no unique 1498-R legal issues raised that would necessarily only pertain to this Provider and covered by this EJR decision that would otherwise require the Board to bifurcate this EJR decision.

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

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
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Robert A. Evarts, Esq.
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FOR THE BOARD:

3/18/2020

X Clayton J. Nix

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

cc: Cecile Huggins, Palmetto GBA
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Electronic Delivery

Corinna Goron
Healthcare Reimbursement Servs., Inc.
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RE: ***EJR Determination***
15-2337GC HRS UHHS 2010 DSH SSI Fraction Medicare Managed Care Part C Days Grp.
15-2338GC HRS UHHS 2010 DSH Medicaid Fraction Medicare Mngd Care Part C Days Grp.

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 26, 2020 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[4] These cases involve the hospital-specific DSH adjustment, which requires the

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

Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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

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

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

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

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

> 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.[11]

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

[19] 69 Fed. Reg. at 49099.

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

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

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

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

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

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

Providers' Request for EJR

The Providers explain that because the Secretary has not acquiesced to the decision in *Allina,* the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (the 2004 Rule). The Board is bound by the 2004 rule and the Providers and the Providers contend that the Board should grant their request for EJR.

The Providers assert that, pursuant to 42 U.S.C. § 1395oo(f)(1), the Board must grant EJR if it lacks the authority to decide a question of "law, regulation or CMS Ruling" raised by a provider. The Providers maintain that the Board is bound by the regulation, there are not factual issues in dispute and the Board does not have the legal authority to decide the issue. Further, the Providers believe they have satisfied the jurisdictional requirements of the statute and the regulations.

Decision of the Board

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

[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.
[29] No. 17-1484, 2019 WL 2331304 (June 3, 2019).

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2010.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[30] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[31]

On August 21, 2008, new regulations governing the Board were effective.[32] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required, for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[33] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[34]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on

[30] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[31] *Bethesda*, 108 S. Ct. at 1258-59.
[32] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[33] 201 F. Supp. 3d 131 (D.D.C. 2016).
[34] *Id.* at 142.

appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R as they are challenging a regulation. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[35] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the 2010 cost reporting period. Thus, the appealed cost reporting periods falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[36] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[37] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

3/18/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Judith Cummings, CGS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Lawrence Getzoff, Esq.
Hooper, Lundy and Bookman, P.C.
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Los Angeles, CA 90067-2517

RE: ***Expedited Judicial Review Determination***
16-0959 San Antonio Community Hospital, Provider No. 05-0099, FYE 12/31/2009
16-2351 Cooper University Hospital, Provider No. 31-0014, FYE 12/31/2011

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' requests for expedited judicial review ("EJR") all of which were received on February 25, 2020 for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue for which EJR has been requested in these appeals is:

> [W]hether the Providers' DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

> 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*

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

> *part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[11]

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

[19] 69 Fed. Reg. at 49099.

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[24] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[26] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare

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[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
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[23] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).

fraction had been vacated in *Allina I*.[27] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[28] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

The Providers believe that by virtue of the statute, Medicare Part C days should not be included in either the numerator or denominator of the Medicare/SSI fraction. The Providers point out that in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), hospital inpatients who are "entitled to benefits under Part A" are to be included in the Medicare/SSI fraction, with all such patients in the denominator and those who are also entitled to SSI in the numerator. Patients enrolled in a Medicare Part C plan may be "eligible" for Part A, but are not "entitled" to Part A benefits during the months when they have given up their Part A entitlement to enroll in Part C. As a result, the Providers assert, inpatient days associated with these patients do not belong in the Medicare/SSI fraction.

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal because the Providers' appeal was timely filed and the $50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the 2004 rule [codified in the 2005 regulation at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B)].

Decision of the Board

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

Jurisdiction

The participants that comprise these appeals within these EJR requests have filed appeals involving fiscal years 2009 and 2011.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-

[27] *Id.* at 943.
[28] *Id.* at 943-945.

disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[29] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[30]

On August 21, 2008, new regulations governing the Board were effective.[31] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[32] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[33]

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

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[29] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[30] *Bethesda at 1258-59.*
[31] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[32] 201 F. Supp. 3d 131 (D.D.C. 2016)
[33] *Banner* at 142.

Jurisdiction and EJR

The Board has determined that the participants involved with the instant EJR requests and which filed from NPRs are governed by CMS Ruling CMS-1727-R because the Providers are challenging a regulation. In addition, the participant's documentation shows that the estimated amount in controversy for each individual appeal exceeds $10,000, as required for an appeal.[34] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction over the above-captioned appeals. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the cost reporting periods 2009 and 2011. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time periods at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[35] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Provider would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[36]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

[34] *See* 42 C.F.R. § 405.1835.
[35] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[36] *See* 42 U.S.C. § 1395oo(f)(1).

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject years. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since the Part C Days issue is the only issue under dispute in these cases, the Board hereby closes the cases.

Board Members Participating:

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

FOR THE BOARD:

3/18/2020

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Solutions c/o Cahaba Safeguard Administrators
Bruce Snyder, Novitas
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Laurence Getzoff
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RE: ***HLB Part C Days Medicaid and Medicare Proxy Groups – EJR Determination***

13-3300G	*HLB Naveos Independent Hospitals 2006 DSH Medicaid Dual Eligible Part C*
13-3874G	*HLB Independent Hospitals 2006 DSH Medicaid Dual Eligible Part C Days*
13-2747G	*HLB Independent Hospitals 2008 DSH Medicaid Dual Eligible Part C Days*
13-2749G	*HLB Independent Hospitals 2007 DSH Medicaid Dual Eligible Part C Days*
14-0394G	*HLB Naveos Independent Hospitals 2009 DSH Medicaid Dual Eligible Part C*
14-4066G	*HLB Naveos Independent Hospitals 2010 DSH Medicaid Fraction-Medicaid*
14-4133G	*HLB Naveos Independent Hospitals 2011 DSH Medicaid Fraction Part C Days*
15-1319G	*HLB Independent Hospitals 2011 DSH Medicaid Fraction Part C Days Group*
14-3369G	*HLB Independent Hospitals 2009 DSH Medicaid Dual Eligible Part C Days*
14-3370G	*HLB Independent Hospitals 2009 DSH SSI Part C Days Group*
16-2513G	*HLB Naveos II Independent Hospitals 2010 DSH Medicaid Dual Eligible Part C*
16-2321G	*HLB Naveos Independent Hospitals 2012 DSH Medicaid Dual Eligible Part C*
15-2874G	*HLB Independent Hospitals 2012 DSH Medicaid Dual Eligible Part C Days*

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeals and, on December 4, 2019, as required by 42 C.F.R. § 405.1842(c), notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above referenced CIRP group cases. The Providers and the Medicare Contractor have also submitted comments as to whether the Board is without the authority to decide the following legal questions[1]:

> Whether the Intermediary failed to include all of the Provider's Medicare part C days in the numerator of the Medicaid Proxy used to calculate the Provider's allowable Medicare disproportionate Share hospital (DSH) payment.[2]

[1] The Provider's comments were received on December 17, 2019, and the Medicare Contractor's comments were received on December 24, 2019.
[2] Request for Hearing, Issue Statement, at Ex. 2 (Aug. 30, 2013), 13-3300G.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Providers' Request for EJR

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

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

Decision of the Board

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

Jurisdiction

The participants addressed in this EJR determination have filed appeals involving fiscal years 2006 to 2012.

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

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[32] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[33]

On August 21, 2008, new regulations governing the Board were effective.[34] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[35] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[36]

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare

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[32] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[33] *Bethesda*, 108 S. Ct. at 1258-59.
[34] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[35] 201 F. Supp. 3d 131 (D.D.C. 2016).
[36] *Id.* at 142.

contractor specifically revised within the revised NPR.[37] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

A. Jurisdictional Determination On Certain Specific Individual Participants

At the outset, the Board notes that a Board finding of jurisdiction is a prerequisite to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority request "[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision,"[38] including documentation relating to jurisdiction. Similarly, the regulations governing group appeals specify that jurisdiction "may be raised at any time."[39]

1. *Case No. 13-3874G – HLB Independent Hospitals 2006 DSH Medicaid Dual Eligible Part C Days Group, Provider #2, San Antonio Community Hospital (05-0099, FYE 12/31/06)*

The Medicare Administrative Contractor ("MAC") filed a formal jurisdictional challenge on March 20, 2015, stating that the provider appealed from a Revised NPR and there was no adjustment to exclude Medicare Part C Days for Provider #2, San Antonio Community Hospital (05-0099); therefore, the MAC contends it has not made a determination with respect to the Provider for the appeal to be based on.

The original issue statement challenged whether CMS, through the MAC, was correct in excluding Medicare Part C Days in the Medicaid Fraction of the Provider's DSH calculation. The MAC acknowledges that it made an adjustment to update both the Medicare and Medicaid Fractions, but argues that these adjustments do not render a final determination with respect to the exclusion of Medicare Part C days from the Medicaid fraction.[40]

The Provider argues that it need only be dissatisfied with a final determination from the MAC in order to satisfy the regulation regarding appeal.[41] Further, the Provider argues that in the reopening that led to the ultimate revised NPR, the MAC adjusted the SSI fraction specifically to include Part C days, reflecting an affirmative act to interpreting the proper location of such Part C days within the DSH calculation.[42]

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2011) provides in relevant part:

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[37] See 42 C.F.R. § 405.1889(b)(1) (2008).
[38] 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which included a decision on both jurisdiction and the EJR request).
[39] 42 C.F.R. 405.1837(e)(2) states: "*The Board may make jurisdictional findings* under § 405.1840 ***at any time***, including, but not limited to, following a request by the providers for the jurisdictional findings. The providers may request jurisdictional findings by notifying the Board in writing that the group appeal is fully formed, or that the providers believe they have satisfied all of the requirements for a group appeal hearing request, and the Board may proceed to make jurisdictional findings."
[40] MAC's Jurisdictional Challenge, at 2 (Mar. 20, 2015), PRRB Case No. 13-3874G.
[41] Provider's Responsive Jurisdictional Brief, at 1 (Jun. 9, 2015).
[42] *Id*. at 2.

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

42 C.F.R. § 405.1889 (2011) explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> …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)).

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[43] The revised NPR appeal included within this challenge was issued after August 21, 2008.

The Board finds that it has jurisdiction as the Provider's DSH Part C Days issue was specifically revised by the revised NPR. In this regard, the Board notes that The Provider filed its appeal from a revised NPR which adjusted Part C Days as part of its adjustment of the Medicare Fractions, as required by 42 C.F.R. § 405.1889 for Board jurisdiction.

[43] See 42 C.F.R. § 405.1889(b)(1) (2008).

2. *Case No. 14-3369G – HLB Independent Hospitals 2009 DSH Medicaid Dual Eligible Part C Days Group, Providers #2 and 3, Tri-City Medical Center (05-0128, FYE 6/30/09), and Wyckoff Heights Medical Center – Brooklyn (33-0221, FYE 12/31/09)*

The MAC filed a formal jurisdictional challenge on March 24, 2016, stating that 2 of the providers Tri-City Medical and Wyckoff Heights Medical Center-Brooklyn, have not properly preserved their right to appeal the issue.

Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

In this regard, Ruling 1727 sets out a five-step analysis for the Board to undertake to determine whether a provider is entitled to a Board hearing for an item that the provider appealed but did not include on its cost report. In short, a provider has a right to a Board hearing for such an item if it excluded the item based upon "a good faith belief that the item was subject to a payment regulation or other policy that gave the Medicare contractor no authority or discretion to make payment in the manner the provider sought."[44]

The first step of analysis under Ruling 1727 involves the appeal's filing date and cost reporting period. The appeal must have been pending or filed after the Ruling was issued on April 23, 2018. In the instant cases, the Board received the Providers' requests for hearing in November 2013 and October 2014. Thus, they satisfy the appeal pending date requirement. Additionally, the Ruling applies to appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016. These appeals involve fiscal year end 2009 cost reports. Thus, the appealed cost reporting period falls within the required time frame.

Second, the Board must determine whether the appealed item "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider."[45]

Under §§ 1815(a) and 1833(e) of the Social Security Act, no Medicare payments are made to a provider unless the provider has furnished information requested by the Secretary so that the Secretary may determine the amount of payment due. With respect to a hospital's Medicare DSH payment—comprised of the Medicare and Medicaid DSH fractions—part of the Secretary's regulations mandate that a DSH-eligible hospital "has the burden of furnishing data

[44] Ruling 1727 at unnumbered page 2.
[45] Ruling 1727 at 6.

adequate to prove eligibility for each Medicaid patient day claimed…and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day."[46]

In the instant appeals, the Providers question whether the inclusion of Medicare Choice/Medicare Advantage Days in the SSI/Medicare Fraction of the Provider's DSH calculation was correct. And that, to the extent these same days are Medicaid eligible, the days should be included in the Medicaid Fraction of the DSH calculation.

As the published SSI ratios for this time period include all Part C days in the SSI fraction, and the providers were barred from also including them in their Medicaid percentage (assuming the patients were dually eligible for Medicaid and Medicare Part C). In other words, this issue meets the second requirement or step of Ruling 1727.

The third, fourth and fifth steps of analysis under Ruling 1727 involve the Board's assessment of whether a provider's appeal has met the jurisdictional requirements set out in the applicable regulation.[47] As the Providers' appeals were timely filed and the estimated amount in controversy is over $10,000, the first two Board jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, Ruling 1727 sets out three different scenarios—in steps three, four and five—for the Board to consider.

The Board looks to step three if it is reviewing an appealed item which was, in fact, within the payment authority or discretion of the Medicare contractor, *i.e.*, an "allowable" item. In the instant appeal, the Dually eligible Part C/Medicaid Eligible Days sought are *not* within the payment authority or discretion of the Medicare Contractor because they are required to use the CMS issued SSI fractions per 42 C.F.R. § 412.106(b)(2) and per that regulations the SSI fraction must include Part C Days.[48]

Under step four of Ruling 1727, the Board does not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable) if a determination has been made that the item under appeal was subject to a regulation or other policy that bound the Medicare Contractor and left it with no authority or discretion to make payment as sought. As discussed in step two above, these DSH Part C/Medicaid Eligible Days are "non-allowable" costs because the Medicare Contractor was bound by 42 C.F.R. § 412.106(b)(2) and per that regulations the SSI fraction must include the dually eligible Part C Days.

Under step five of Ruling 1727, the Board is directed to consider the circumstances surrounding a provider's self-disallowance claim. In the instant appeals, however, the Provider did not self-disallow the DSH Medicaid Eligible Days issue, thus this step is not applicable to this appeal.

The Board finds that the Providers' Part C Days issue is within the Board's jurisdiction, based upon the *Bethesda* rationale and Ruling 1727-R, as it would have been futile to present the dually eligible Part C/Medicaid Eligible Days to the Medicare Contractor as they are already included

[46] 42 C.F.R. § 412.106(b)(4)(iii) (2010).
[47] 42 C.F.R. § 405.1835(a) (2010).
[48] *See* 42 C.F.R. §§ 412.106(b)(2)(i)(B), 412.106(b)(2)(iii)(B).

in their respective SSI fraction. The Providers did not have to protest the Part C issue as the Medicare Contractor had no authority to include the days in the Medicaid fraction as CMS had already included them in their respective Medicare fraction.

3. *Case No. 14-3370G – HLB Independent Hospitals 2009 DSH SSI Part C Days Group, Provider #5, Wyckoff Heights Medical Center – Brooklyn (33-0221, FYE 12/31/09)*

The MAC filed a formal jurisdictional challenge on March 24, 2016, stating that one of the providers, Wyckoff Heights Medical Center-Brooklyn, has not properly preserved their right to appeal the issue.

Relying on the same analysis as above, the Board finds that the Provider's appeal is governed by CMS-1727R as the Provider is challenging a regulation. The Provider filed a timely appeal, and the Provider and the MAC were barred from claiming the days in the Medicaid fraction as CMS had already included them in their respective Medicare fraction. The Board concludes that it has jurisdiction over the Provider for Medicare Advantage Part C days in the DSH adjustment issue in the case.

4. *Case No. 14-4133G – HLB Naveos Independent Hospitals 2011 DSH Medicaid Fraction Part C Days Group, Provider #1, Mississippi Baptist Medical Center (25-0102, FYE 8/31/11)*

The MAC filed a formal jurisdictional challenge on June 6, 2018, stating that no protest was made regarding Medicare Part C Days for Provider #1, Mississippi Baptist Medical Center (25-0102); therefore, the MAC contends the provider has not preserved the issue for the appeal.

The Provider argues that CMS Ruling 1727-R compels the Board to reject the MAC's jurisdictional challenge, and that the Provider has met all statutory appeal requirements.

Relying on the same analysis as above, the Board finds that the Provider's appeal is governed by CMS-1727R as the Provider is challenging a regulation. The Provider filed a timely appeal, and the Provider and the MAC were barred from claiming the days in the Medicaid fraction as CMS had already included them in their respective Medicare fraction. The Board concludes that it has jurisdiction over the Provider for Medicare Advantage Part C days in the DSH adjustment issue in the case.

5. *Case No. 15-1319G – HLB Independent Hospitals 2011 DSH Medicaid Fraction Part C Days Group, Providers #1,2, and 3, Tri-City Medical Center (05-0128, FYE 6/30/11), Maury Regional Hospital (44-0073, FYE 6/30/11), and San Antonio Community Hospital (05-0099, FYE 6/30/11)*

The MAC filed a formal jurisdictional challenge on June 9, 2016, stating that 3 of the 4 providers have not properly preserved their right to appeal issue. None protested the issue, 1 had an

adjustment to Medicaid but not for Part C days (Maury Regional), and 2 had no adjustment to Medicaid days (Tri-City and San Antonio).

The Providers argue in response that they met all statutory appeal requirements and protested the DSH calculation and the Medicaid Days.

Relying on the same analysis as above, the Board finds that the Providers' appeals are governed by CMS-1727R as the Providers are challenging a regulations. The Providers filed timely appeals, and the Providers and the MAC were barred from claiming the days in the Medicaid fraction as CMS had already included them in their respective Medicare fraction. The Board concludes that it has jurisdiction over the Providers for Medicare Advantage Part C days in the DSH adjustment issue in the case.

6. *Case No. 15-2874G – HLB Independent Hospitals 2012 DSH Medicaid Dual Eligible Part C Days Group, Providers #1, 2, and 3, Pomona Valley Hospital Medical Center (05-0231, FYE 12/31/12), Brotman Medical Center (05-0752, FYE 12/31/12), and Maury Regional Hospital (44-0073, FYE 6/30/12)*

The MAC filed a group problem upon jurisdictional review of the fully formed group appeal on November 18, 2016, arguing that none of the providers preserved their right to appeal. The MAC contends that they failed to document any of the adjustments related to the removal of Part C days or that the issue was properly included as a protested item on the filed cost report. They note that one provider references a protest adjustment, but failed to provide evidence that this issue was a protest item and included in the protest amount that was removed at audit.

In a responsive brief filed on December 16, 2016, the Providers argue in response that they have met all statutory appeal requirements and the self-disallowance regulation is inapplicable to this appeal; that the providers have jurisdictionally valid appeals; and that specifically, Pomona Valley protested the issue in its cost report.

Relying on the same analysis as above, the Board finds that the Providers' appeals are governed by CMS-1727R as the Providers are challenging a regulation. The Providers filed timely appeals, and the Providers and the MAC were barred from claiming the days in the Medicaid fraction as CMS had already included them in their respective Medicare fraction. The Board concludes that it has jurisdiction over the Providers for Medicare Advantage Part C days in the DSH adjustment issue in the case.

B. Jurisdictional Determination for Remaining Participants

The Board has determined that the remaining participants' appeals involved with the instant EJR Request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R as they are challenging a regulation and that those remaining participant appeals filed from a revised NPR have the appropriate adjustment to the Part C days issue within the revised NPR. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as

required for a group appeal[49] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Accordingly, the Board finds that it has jurisdiction for the referenced appeals and the remaining participants.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the fiscal years 2006 to 2012 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[50] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[51] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

Board's Decision Regarding the EJR

The Board finds that:

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

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

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

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

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[49] *See* 42 C.F.R. § 405.1837.
[50] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[51] *See* 42 U.S.C. § 1395oo(f)(1).

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the EJR for the issue and the subject years. The participants have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes those cases.

Board Members Participating:

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Charlotte F. Benson, CPA
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For the Board:

3/18/2020

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Corinna Goron
Healthcare Reimbursement Servs., Inc.
17101 Preston Rd, Ste. 220
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RE: ***Expedited Judicial Review Determination***

13-3615G	HRS 2008 DSH Payment Dual Eligible Days Group
14-3511G	HRS 2008 DSH SSI Fraction Dual Eligible Days Group
14-0711G	HRS 2009 DSH Medicaid Fraction Dual Eligible Days Group
14-3509G	HRS 2009 DSH SSI Fraction Dual Eligible Days Group
14-2454G	HRS 2010 DSH SSI fraction Dual Eligible Days Group
15-2455G	HRS 2010 DSH Medicaid Fraction Dual Eligible Days Group II
17-1888G	HRS 2012 DSH SSI Fraction Dual Eligible Days Group II
17-1889G	HRS 2012 DSH Medicaid Fraction Dual Eligible Days Group II

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 25, 2020 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> Whether the MAC [Medicare Administrative Contractor] should have excluded from the Medicare fraction non-covered patient days, *i.e.*, days attributable to patients who were enrolled in Medicare and entitled to SSI [Supplemental Security Income], but for whom Medicare did not make a payment for their hospital stay, either because that patient's Medicare benefit days were exhausted, or because a third party made payment for that patient's hospital stay.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] Providers' EJR request at 2.

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

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

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

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

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

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

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

> 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

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

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

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

Dual Eligible Days

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.[13] 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.[14]

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."[15] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[16] The Secretary then summarized its policy by stating that "our 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."[17]

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).[18] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for

[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(4).
[13] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.* at 27207-27208.
[18] *Id.* at 27207-08.

Medicare contractor's[19] 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.[20]

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.[21] 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.[22] 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. [23] 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.[24]

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.[25] Rather, he 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."[26]

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.[27]

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:

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[19] MACs were formerly known as fiscal intermediaries or intermediaries.
[20] 68 Fed. Reg. at 27208.
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[26] *Id.*
[27] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> 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.[28]
>
> ****
>
> . . . [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.*[29]

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."[30] 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."[31] 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—

[28] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004).
[29] *Id.* at 49099 (emphasis added).
[30] *Id.*
[31] *See id.* at 49099, 49246.

> (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 . . .

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 . . .

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."[32]

The Board notes that two courts have reviewed and upheld 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*"),[33] the 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.[34] 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.[35] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[36] The *Stringfellow* decision was appealed to the D.C. Circuit Court of Appeals; however, it was later dismissed.[37]

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[32] *Id.*
[33] 317 F. Supp. 3d 168 (D.D.C. 2018).
[34] *Id.* at 172.
[35] *Id.* at 190.
[36] *Id.* at 194.
[37] *See* 2019 WL 668282.

In the second case, *Empire Health Found. v. Price* ("*Empire*"),[38] 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."[39] 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.[40] 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[41] and that the regulation is procedurally invalid.[42] The *Empire* decision is currently pending on appeal in the Ninth Circuit Court of Appeals.[43]

As of the date of this decision, the Secretary's position with respect to the validity of the regulation has not changed.

Providers' Request for EJR

The Providers contend that the non-covered patient, *i.e.*, days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make payment for their hospital stays because the patient's Medicare patient days were exhausted or because a third party made payment, should be excluded from the Medicare fraction of the DSH fraction. The Providers believe that these non-covered patient days should be treated consistently: (1) they should be included in both the top and bottom of the SSI fraction; or (2) excluded from the top and bottom of the SSI fraction and then be recognized in the numerator of the Medicaid fraction.[44]

The Providers explain that the applicable regulations require that non-covered patient days be included in the Medicare fraction, even though the change made to the regulations effective October 1, 2004. This was accomplished by the deletion of the word "covered" where it had previously appeared in the definition of the Medicare fraction in 42 C.F.R. § 412.106(b)(2)(i). As a result of this change, the regulation now requires the inclusion in the Medicare fraction of both exhausted benefit and Medicare secondary payment days associated with patient discharges occurring on or after October 1, 2004.

[38] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[39] *Id.* at 1141.
[40] *Id.*
[41] *Id. at 1162.*
[42] *Id. at 1163*
[43] PACER: https://ecf.ca9.uscourts.gov/n/beam/servlet/TransportRoom. (last visited 02/05/2020).
[44] Providers' EJR Request at 2.

The Providers assert that the Secretary improperly promulgated the revision to § 412.106(b)(2)(i) as part of the FY 2005 IPP final rule and that this revision should be vacated. In support of its position, the Providers note that, in *Allina Health Servs. v. Sebelius* ("*Allina*"), the D.C. Circuit recently invalidated a different regulatory revision made in the same rulemaking.[45] In *Allina*, the D.C. Circuit vacated the Secretary's regulation requiring Part C days be included in the Medicare fraction where the Secretary's policy prior to October 1, 2004 was to exclude Part C days from the Medicare fraction. The Court concluded that the Part C days regulation was not a logical outgrowth of the proposed regulation and that the proposed rule was merely an indication that the Secretary was considering a clarification of existing policy rather a reversal of the existing policy.

The Providers argue that the dual eligible days proposed rule as published in the FY 2004 IPPS proposed rule was equally misleading with respect to the Secretary's policy. As with the Secretary's Part C days policy, the Secretary adopted a policy with regard to dual eligible days that was the reverse of the proposed regulation and erroneously described the policy with respected to dual eligible days in the FY 2004 IPPS proposed rule. The Provider's contend that the convoluted nature of this rulemaking in which the Secretary both got her facts mixed up while at the same time shifting positions could only create among the public the type of hopeless confusion which the D.C. Circuit found in *Allina.*[46]

The Providers maintain that the Secretary denied the public a meaningful opportunity to comment on the proposed regulations. There was nothing in the proposed regulations that suggested the possibility of anything other than the inclusion of non-covered days in the Medicare fraction or inclusion of non-covered days in the Medicaid fraction. As a result, the Providers maintain, the public was deprived of a meaningful opportunity to comment.

The Providers point out that there are no factual matters to be resolved with respect to the issue in these cases and the Board has jurisdiction over the appeals. The Providers maintain that EJR is appropriate since the Board is without the authority to grant the relief sought, namely a finding that as a matter of law 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid.

[45] 746 F. 3d 1102 (D.C. Cir. 2014)
[46] *Id.* at 1107.

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2008, 2009, 2010 and 2012.
For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[47] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[48]

On August 21, 2008, new regulations governing the Board were effective.[49] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required, for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[50] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[51]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare

[47] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[48] *Bethesda*, 108 S. Ct. at 1258-59.
[49] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[50] 201 F. Supp. 3d 131 (D.D.C. 2016).
[51] *Id.* at 142.

Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016. Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

Jurisdiction and EJR

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R as the Providers are challenging the validity of a regulation. The appeals were timely filed and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[52] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying, remaining providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

The Board finds that it lacks the authority to grant the relief sought by the remaining Providers, namely a finding that 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid. Consequently, the Board finds that EJR is appropriate.

Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon thevparticipants' 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 valid.

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 the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from

[52] *See* 42 C.F.R. § 405.1837.

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:

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

FOR THE BOARD:

3/24/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
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Via Electronic Delivery

Kenneth R. Marcus, Esq.
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RE: **Expedited Judicial Review Determination**
Covenant Medical Center (Prov. No. 23-0070)
FFY 2020
Case No. 20-0550

Dear Mr. Marcus:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's February 27, 2020 request for expedited judicial review ("EJR") for the case referenced above. The Board decision determining that EJR is appropriate for the issue and Federal fiscal year under appeal is set forth below.

Issue in Dispute

The Provider is challenging:

> Whether the Centers for Medicare [&] Medicaid Services imposing a 0.7% reduction (the "IPPS Rate Reduction" in the Medicare Inpatient Prospective System ("IPPS") standardized amount is consistent with applicable law?[1]

Statutory and Regulatory Background

In the federal year ("FY") 2008 inpatient prospective payment system ("IPPS") final rule,[2] the Secretary[3] adopted the Medicare severity diagnosis-related group ("MS–DRG") patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The Secretary believes that, by increasing the number of MS–DRGs and more fully taking into

[1] Provider's EJR request at 1.
[2] 72 Fed. Reg. 47130, 47140 through 47189 (Aug. 22, 2007)
[3] of the Department of Health and Human Services.

account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs will encourage hospitals to improve their documentation and coding of patient diagnoses.[4]

In the FY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FY 2008, -1.8 percent for FY 2009, and -1.8 percent for FY 2010.[5]

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 ("TMA").[6] TMA § 7(a) reduced the documentation and coding adjustment made as a result of the MS–DRG system that the Secretary adopted in the FY 2008 IPPS final rule to -0.6 percent for FY 2008 and -0.9 percent for FY 2009.[7]

The Secretary implemented a series of adjustments required under TMA §§ 7(b)(1)(A) and 7(b)(1)(B) based on a retrospective review of FY 2008 and FY 2009 claims data. The Secretary completed these adjustments in FY 2013. However, the Secretary commented in the FY 2013 IPPS final rule that delaying full implementation of the adjustment required under TMA § 7(b)(1)(A) until FY 2013 had resulted in payments in FY 2010 through FY 2012 being overstated, and that these overpayments could not be recovered.[8]

Congress revisited TMA § 7(b)(1)(B) as part of the American Taxpayer Relief Act of 2012 ("ATRA").[9] Specifically, ATRA § 631 amended TMA § 7(b)(1)(B) to add clause (ii) which required the Secretary to make a recoupment adjustment or adjustments totaling $11 billion for discharges occurring during FYs 2014 to 2017. Per the revisions made by ATRA § 631(b), this adjustment "represents the amount of the increase in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied" (*i.e.*, represents the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under TMA § 7(b)(1)(A) until FY 2013).[10] As discussed above, this delay in implementing TMA § 7(b)(1) resulted in overstated payment rates in FYs 2010, 2011, and 2012 and the resulting overpayments could not have been recovered under the original TMA § 7(b).

[4] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).
[5] *See* 82 Fed. Reg. 37990, 38008 (Aug. 14, 2017).
[6] Pub. L. 110–90, 121 Stat. 984 (2007).
[7] *Id.* at 986.
[8] *See* 82 Fed. Reg. at 38008.
[9] Pub. L. 112-240, 126 Stat. 2313 (2013).
[10] *Id.* at 2353.

The adjustment required under ATRA § 631 was a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, the Secretary "anticipated that any adjustment made to reduce payment rates in one year would eventually be offset by a positive adjustment in FY 2018, once the necessary amount of overpayment was recovered."[11]

However, Congress again stepped in to revise TMA § 7(b)(1)(B). First, in § 414 of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Congress revised TMA § 7(b)(1)(B) to add clause (iii) which replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023.[12] Second, in § 15005 of the 21st Century Cures Act ("21-CCA"),[13] Congress amended the MACRA revision in TMA § 7(b)(1)(B)(iii) by reducing the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points.[14]

The Secretary's "actuaries estimated that a -9.3 percentage point adjustment to the standardized amount would be necessary if CMS were to fully recover the $11 billion recoupment required by [ATRA § 631] in FY 2014." Consistent with the policies that the Secretary has adopted in many similar situations, the Secretary implemented a phased in approach. For the first year, FY 2014, he implemented a -0.8 percentage point recoupment adjustment to the standardized amount. The Secretary declined, at that time, to set specific adjustments for FYs 2015, 2016, or 2017 "[a]s estimates of any future adjustments are subject to variations in total savings[.]"[15] However, he did estimate that, if adjustments of -0.8 percentage point were implemented in FYs 2014, 2015, 2016, and 2017, using standard inflation factors, then the requisite $11 billion would be recouped by the end of the statutory 4-year timeline.[16]

Consistent with the approach discussed in the FY 2014 rulemaking for recouping the $11 billion required by ATRA § 631, in the FY 2015 IPPS/LTCH PPS final rule[17] and the FY 2016 IPPS/LTCH PPS final rule,[18] the Secretary implemented additional -0.8 percentage point recoupment adjustments to the standardized amount in FY 2015 and FY 2016, respectively. The Secretary estimated that these adjustments, combined with leaving the prior -0.8 percentage point adjustments in place, would recover up to $2 billion in FY 2015 and another $3 billion in FY 2016. When combined with the approximately $1 billion adjustment made in FY 2014, the Secretary estimated that approximately $5 to $6 billion would be left to recover under ATRA § 631 by the end of FY 2016.

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[11] 82 Fed. Reg. at 38008.
[12] Pub. L. 114–10, § 414, 129 Stat. 87, 162-163 (2015).
[13] Pub. L. 114–255, 130 Stat. 1033 (2016).
[14] *Id.* at 1319-1320. *See also* 82 Fed. Reg. at 38008.
[15] 82 Fed. Reg. at 38008.
[16] *Id.*
[17] 79 Fed. Reg. 49853, 49874 (Aug. 22, 2014).
[11] 80 Fed. Reg. 49326, 49345 (Aug. 17, 2015).

In the FY 2017 IPPS/LTCH PPS proposed rule,[19] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under ATRA § 631. For the FY 2017 IPPS/LTCH PPS final rule,[20] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FY 2014 through FY 2017 without exceeding this amount is -1.5 percentage points. Based on those updated estimates by the Office of the Actuary, the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under ATRA § 631.[21]

Once the recoupment required under ATRA § 631 was complete, the Secretary anticipated making a single positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631. However, MACRA § 414 (which was enacted on April 16, 2015) replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. In the FY 2017 rulemaking, the Secretary indicated that he would address the adjustments for FY 2018 and later fiscal years in future rulemaking. As noted previously, 21-CCA § 15005, which was enacted on December 13, 2016, amended TMA § 7(b)(1)(B) (as amended by ATRA § 631 and MACRA § 414) to reduce the adjustment for FY 2018 from a 0.5 percentage point to a 0.4588 percentage point. The Secretary believes the directive under 21-CCA § 15005 is clear and, as a result, in the FY 2018 IPPS/LTCH PPS proposed rule for FY 2018, the Secretary proposed to implement the required +0.4588 percentage point as a permanent adjustment to the standardized amount.[22]

The IPPS Final Rule for FY 2018

In response to the +0.4588 percentage point adjustment, several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FY 2017 under ATRA § 631, which exceeded the estimated adjustment of approximately -0.8 percentage point described in the FY 2014 IPPS/LTCH PPS rulemaking. Commenters contended that, as a result, hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA. They asserted that CMS' proposal to apply a 0.4588 percent positive adjustment for FY 2018 misinterprets the relevant statutory authority, and urged the Secretary to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FY 2018 (*i.e.*, the difference between the -1.5 percentage point adjustment made in FY 2017 and the initial estimate of -0.8 percentage point discussed in the FY 2014 IPPS/LTCH PPS rulemaking). The commenters also urged the Secretary to use his discretion under 42 U.S.C. § 1395ww(d)(5)(I) to increase the FY 2018 adjustment by 0.7 percentage point. Other commenters requested that, despite current law, CMS ensure that adjustments totaling the full 3.9 percentage points withheld under ATRA § 631 be returned.[23]

[19] 81 Fed. Reg. 24946, 24966 (Apr. 27, 2016)
[20] 81 Fed. Reg. 56761 (Aug. 22, 2016).
[21] *Id.* at 56785.
[22] 82 Fed. Reg. at 38009.
[23] *Id.*

The Secretary responded by stating that, as discussed in the FY 2017 IPPS/LTCH PPS final rule, CMS had completed the $11 billion recoupment required under ATRA § 631.[24] The Secretary also continued to disagree with commenters who asserted that MACRA § 414 was intended to augment or limit the separate obligation under the ATRA to fully offset $11 billion by FY 2017.[25] Moreover, the Secretary pointed out in the FY 2018 IPPS/LTCH PPS proposed rule, he believes that the directive regarding the applicable adjustment for FY 2018 is clear. While the Secretary had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 requires that he not make the single positive adjustment he intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. The Secretary pointed out that, as noted by the commenters and discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage point adjustment originally estimated in the FY 2014 IPPS/LTCH PPS final rule.[26] Finally, the Secretary notes that 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and that this change was enacted on December 13, 2016, ***after*** CMS had proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under ATRA § 631 in the FY 2017 rulemaking. The Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under 21-CCA § 15005.[27]

The FY 2019 Adjustment to the Standardized Amount

In the FY 2019 IPPS final rule,[28] the Secretary finalized a +0.5 percentage point adjustment to the standardized amount for FY 2019, as required under MACRA § 414.

In the FY 2019 IPPS final rule, several commenters argued that the Secretary misinterpreted the Congressional directives regarding the level of positive adjustment required for FYs 2018 and 2019. The commenters contended that, while the positive adjustments required under MACRA § 414 would only total 3.0 percentage points by FY 2023, the levels of these adjustments were determined using an estimated positive ‘‘3.2 percent baseline’’ adjustment that otherwise would have been made in FY 2018. The commenters believed that, because CMS implemented an adjustment of -1.5 percentage points instead of the expected -0.8 percentage points in FY 2017, totaling -3.9 percentage points overall, the Secretary has imposed a permanent -0.7 percentage point negative adjustment beyond its statutory authority, contravening what the commenters contend was Congress' clear instructions and intent. The commenters requested that the Secretary reverse his previous position and implement additional 0.7 percentage point adjustments for both FY 2018 and FY 2019. Some of the commenters requested that the Secretary use his statutory discretion to ensure that all 3.9 percentage points in negative adjustment be restored. In addition, some of the commenters acknowledged that CMS may be

[24] *Id.* (citing 81 Fed. Reg. at 56783-85).
[25] *Id.* (citing 81 Fed. Reg. at 56784).
[26] *Id.* (citing 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013)).
[27] *Id.*
[28] 83 Fed. Reg. 41144 (Aug. 17, 2018).

bound by law but expressed opposition to the permanent reductions and requested that the Secretary refrain from making any additional coding adjustments in the future.[29]

The Secretary responded by stating that, as discussed in the FY 2019 IPPS/LTCH PPS proposed rule, he believes MACRA § 414 and 21-CCA § 15005 clearly set forth the levels of positive adjustments for FYs 2018 through 2023.[30] He was not convinced that the adjustments prescribed by MACRA were predicated on a specific ''baseline'' adjustment level. While he had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 required that a 0.5 percentage point positive adjustment be implemented for each of FYs 2018 through 2023, rather than the single positive adjustment he had anticipated making in FY 2018. As discussed in the FY 2017 IPPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage points adjustment originally estimated in the FY 2014 IPPS final rule.[31] Moreover, as discussed in the FY 2018 IPPS final rule, 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and this adjustment was enacted on December 13, 2016, ***after*** the Secretary had proposed and finalized the final negative -1.5 percentage points adjustment required under ATRA § 631. The Secretary does not believe that Congress enacted these adjustments with the intent that there would be an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017.[32]

The FY 2020 Adjustment to the Standardized Amount

Again, in the FY 2020 IPPS final rule, the Secretary implemented a 0.5 percentage point positive adjustment to the standardized amount for FY 2020 consistent with the requirements of MACRO § 414. The Secretary stated that this would constitute a permanent adjustment to payment rates.[33]

Commenters stated that in order to comply with ATRA requirements, the Secretary anticipated that a cumulative -3.2 percentage point adjustment to the standardized amount would achieve the mandated $11 billion recoupment. The Commenters stated that they believed that the Secretary misinterpreted the relevant statutory authority, which they asserted explicitly assumes that recoupment under ATRA § 631 would result in an estimated -3.2 percentage point cumulative adjustment by FY 2017. The Commenters asserted that the additional -0.7 percentage point adjustment made in FY 2017 has been improperly continued in FYs 2018 and 2019, and failure to restore the additional 0.7 percentage point adjustment would make this reduction in hospital payments a permanent part of the baseline calculation of the IPPS rates, which, they contend, was not Congress's legislative intent in implementing the series of adjustments required under MACRA § 414.[34]

[29] *Id.* at 41157.
[30] *Id.*
[31] *Id.* (citing 78 Fed. Reg.at 50515).
[32] *Id.*
[33] 84 Fed. Reg. 42044, 42057 (Aug. 16, 2019).
[34] *Id.*

Further, Commenters urged the Secretary to use his exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I) to restore an additional 0.7 percentage point payment adjustment in FY 2020 to restore payment equity to hospitals and comply with what they asserted was Congressional intent. In addition, the Commentators suggested the Secretary implement an approximate positive adjustment of 1.0 percentage point by FY 2024 to fully and permanently restore the entire -3.9 percentage point recoupment adjustment to IPPS rates.[35]

In response, the Secretary noted that he had responded to similar comments in the FY 2019 IPPS final rule and believes that MACRA § 414 and 21-CCA § 15005 set forth the levels of positive adjustments for FYs 2018 through 2023.[36] He is not convinced that the adjustments prescribed by MACRA were predicated on a specific adjustment level estimated or implemented by in previous rulemaking. While the Secretary had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 required that we implement a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023, and not the single positive adjustment the Secretary intended to make in FY 2018. As discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage point adjustment originally estimated by the Secretary in the FY 2014 IPPS/LTCH PPS final rule.[37]

Moreover, as discussed in the FY 2018 IPPS/LTCH PPS final rule, 21-CCA § 15005, which further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point, was enacted on December 13, 2016, ***after*** CMS had proposed and finalized the final negative -1.5 percentage point adjustment required under ATRA § 631. The Secretary saw no evidence that Congress enacted these adjustments with the intent that CMS would make an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017, nor was he persuaded that it would be appropriate to use the Secretary's exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I) to adjust payments in FY 2020 to restore any additional amount of the original 3.9 percentage point reduction, given Congress' prescriptive adjustment levels under MACRA § 414 and 21-CCA § 15005.[38]

Provider's Position

The Provider contends that the IPPS Medicare payment for each Provider will be adversely impacted by the IPPS rate reduction during FY 2020. The Provider further contends that the authority of the Secretary to impose the rate reduction is based exclusively on 42 U.S.C. § 1395ww and that, absent any explicated statutory authority, the rate reduction necessarily is in excess of statutory authority.

[35] *Id.*
[36] *Id.* (citing to 83 Fed. Reg. at 51157).
[37] *Id.*
[38] *Id.*

The Provider maintains that the Secretary cites no statutory authority for the 0.7 percent rate reduction for FY 2018 and after and that, therefore, the rate reduction is in excess of statutory authority. The Provider further maintains that the statutory chronology demonstrates that the entire adjustment was originally to be eliminated through a one-time increase in IPPS payments in FY 2018. The Provider believes that, subsequently, due to the need for savings to offset the MACRA reform of the sustainable growth rate for Medicare physician payment, Congress instructed the Secretary to delay the FY 2018 restoration of the estimated 3.2 percent negative adjustments required by ATRA by implementing a 6-year schedule for certain restorative adjustments. The Provider notes that MACRA was enacted before the Secretary proposed increasing the planned ATRA adjustment for FY 2017 and that Congress expressly provided that the adjustment being delayed was "estimated to be an increase of 3.2 percent." Congress then enacted the 21-CCA in 2017, further reducing the standardized adjustment by 0.0412 percentage points. However, the Provider asserts that Congress did not amend the statute to reference the final ATRA adjustment of 3.9 percent and that, instead, Congress left in the statement that the adjustment was estimated to be 3.2 percent.

In the FY 2018 IPPS final rule, the Secretary indicated that MACRA and the 21-CCA require him to make a positive adjustment of only 0.4599 percentage points to the standardized amount for FY 2018, with 5 additional adjustments of 0.5 percent in each of the next 5 years. As a result, the Secretary never restores the 0.7 percent excess ATRA adjustment it implemented in FY 2017 and by FY 2023, there will be a remaining negative adjustment of 0.9412 percent. The Provider believes that the financial impact to hospitals of the annual 0.7 percent reduction to the IPPS base rate is roughly $900 million per year, or about $200,000 per Medicare-participating hospital through 2023, if not beyond. The Provider contends that the Secretary erroneously interprets MACRA as requiring a continued additional 0.7 percent ATRA adjustment.

Decision of the Board

A. Jurisdiction and Request for EJR

As previously noted, this Provider appealed from the FFY 2020 IPPS final rule.[39] The Board has determined the Provider's documentation establishes that the estimated amount in controversy exceeds $10,000 in compliance with the requirements for an individual appeal[40] and that the Provider timely filed the appeal. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

[39] The CMS Administrator has determined that a Federal Register notice is a final determination from which a provider may appeal to the Board. *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*), rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015).
[40] *See* 42 C.F.R. § 405.1835.

B. Application of 42 C.F.R. § 405.1873

The Board notes that the *cost reporting period(s)* for the Provider that are impacted by the FFY 2020 IPPS final rule begin well after January 1, 2016 and, as such, are subject to the newly-added 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports.[41] However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether the relevant cost report(s) for the Provider included an appropriate claim for the specific item under appeal, presumably because any such potential issue is not yet ripe. In this regard, the Board notes that the Provider is appealing the FFY 2020 Federal Register Notice and the cost report(s) impacted by such notice have not yet been filed to trigger § 413.24(j)'s general substantive payment requirement for cost reports.[42]

C. Analysis Regarding Appealed Issue

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply with the 0.7 percent reduction to the IPPS standard amount for FY 2020 as published in the FY 2020 IPPS Final Rule on August 16, 2019 because CMS clearly intended to bind all hospitals, which are subject to IPPS, to this payment reduction and, as such, it is an uncodified regulation adopted through the Federal Register rulemaking process. Accordingly, the Board concludes that it lacks the authority to grant the relief sought by the Providers, to reverse or otherwise invalidate the negative adjustment of 0.7 percent to the IPPS standard amount for FY 2020 as published in the FY 2020 IPPS Final Rule. Consequently, the Board hereby grants EJR for the issue and FFY under dispute.

The Board finds that:

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

2) Based upon the participant's assertions regarding the 0.7 percent reduction to the IPPS standardized amount, 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 the 0.7 percent reduction to the FY 2020 IPPS standardized amount as published in the FY 2020 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the 0.7 percent reduction to the FY 2020 IPPS rate as published in the FY 2020 IPPS Final Rule properly falls within the

[41] *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015).
[42] *See* 80 Fed. Reg. at 70556, 70569-70.

provisions of 42 U.S.C. § 1395oo(f)(1) and hereby finds that EJR is appropriate for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

3/27/2020

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Electronic Delivery

Corinna Goron
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RE: ***EJR Determination***
14-2994GC HRS LSU 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group
14-2995GC HRS LSU 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 4, 2020 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[4] These cases involve the hospital-specific DSH adjustment, which requires the

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

Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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

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

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

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

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

> 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.[11]

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

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

Medicare Advantage Program

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

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

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

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

With the creation of Medicare Part C in 1997,[16] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services.
[14] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[15] *Id.*
[16] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [17]

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

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

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

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

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Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

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

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

[19] 69 Fed. Reg. at 49099.

> regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20]

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[24] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[26] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[27] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[28] Once again, the Secretary has not acquiesced to

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[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] 72 Fed. Reg. at 47411.
[23] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.

this decision. The Supreme Court issued a decision in *Azar v. Allina Health Services*[29] in which the Court considered whether the government had violated the 60-day notice requirement of 42 U.S.C. § 1395hh(a)(2) when it posted the 2012 Medicare fractions on its website. Affirming the court of appeals finding, the Court concluded that §1395hh(a)(2) the government's action changed a substantive legal standard and, thus required notice and comment.

Providers' Request for EJR

The Providers explain that "[b]ecause the Secretary has not acquiesced to the decision in *Allina [I],* the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The '2004 Rule'). The Board is bound by the 2004 rule."[30] Accordingly, the Providers contend that the Board should grant their request for EJR.

The Providers assert that, pursuant to 42 U.S.C. § 1395oo(f)(1), the Board must grant EJR if it lacks the authority to decide a question of "law, regulation or CMS Ruling" raised by a provider. The Providers maintain that the Board is bound by the regulation, there are not factual issues in dispute and the Board does not have the legal authority to decide the issue. Further, the Providers believe they have satisfied the jurisdictional requirements of the statute and the regulations.

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2011.

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

[29] No. 17-1484, 2019 WL 2331304 (June 3, 2019).
[30] Providers' EJR Request at 1.

Bowen ("*Bethesda*").[31] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[32]

On August 21, 2008, new regulations governing the Board were effective.[33] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required, for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[34] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[35]

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

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R as they are challenging a regulation. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[36] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying, remaining

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[31] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[32] *Bethesda*, 108 S. Ct. at 1258-59.
[33] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[34] 201 F. Supp. 3d 131 (D.D.C. 2016).
[35] *Id.* at 142.
[36] *See* 42 C.F.R. § 405.1837.

providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the 2011 cost reporting period. Thus, the appealed cost reporting periods falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[37] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[38] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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

Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

Board Members Participating:

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FOR THE BOARD:

3/31/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Justin Lattimore, Novitas Solutions
Wilson Leong, FSS