DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

George Ritter
Wise Carter Child & Caraway, P.A.
401 East Capitol Street, Ste. 600
Jackson, MS 39205

RE: ***Part C Days Medicaid and Medicare Proxy – EJR Determination***
South Central Regional Medical Center (Prov. No. 25-0058)
FYE 09/30/2007, 09/30/2008, 09/30/2009, 09/30/2010
Case Nos. 13-3338, 13-3356, 14-0269, 14-4392

Dear Mr. Ritter:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced appeals and, on December 31, 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]:

> Whether CMS improperly included Medicare Part C (M+C) days in the numerator of the Medicare/SSI fraction and improperly excluded Medicare Part C (M+C) days from the numerator and denominator of the Medicare fraction.[2]

Set forth below is the Board's determination on the EJR request.

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 (Aug. 28, 2013), PRRB Case No. 13-3338; *See also id*. PRRB Case Nos. 13-3356, 14-0269, and 14-4392.
[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]

---

[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.

---

[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.

A. EJR Determination for DSH Part C Days Issue

The participants addressed in this EJR determination have filed appeals involving fiscal years 2007 through 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 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 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.

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 referenced appeals for the Part C days issue.

---

[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.

B. Board's Analysis Regarding the Appealed Issue

The appeals in these cases involve the 2007 through 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 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]

C. Board's Decision Regarding the EJR

The Board finds that:

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

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

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (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 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. These cases remain open as there is one remaining issue.

---

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

Board 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:

4/2/2020

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

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***
14-0735GC Good Shepherd Health System 2008 Medicare Fraction Dual Eligible Group
14-3797GC Good Shepherd Health System 2010 DSH Dual Eligible Days Group
15-1145GC Good Shepherd Health System 2012 DSH Dual Eligible Days Group
16-1137GC Hall Render Northshore University 2011 DSH Dual Eligible Days Group
17-0362GC Good Shepherd Health System 2013 DSH SSI Fraction Dual Eligible Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 3, 2020 request for expedited judicial review ("EJR") (March 4, 2020) in the five (5) above-referenced common issue related party ("CIRP") group appeals.[1] The Board's decision with respect EJR is set forth below.

Issue in Dispute

The issue for which the Board is considering EJR is:

> [W]hether the Providers' Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[2]

[1] The EJR request also included Case No. 19-0622G, Hall Render 2012 DSH SSI Fraction Dual Eligible Days Group. The Board will be issuing correspondence for this optional group appeal under separate cover.
[2] Providers' EJR Request at 2. The appeal requests for Case Nos. 14-0735GC, 14-3797GC, and 15-1145GC included the challenge not only to the DSH fraction, but also to the low income patient (LIP) fraction for Inpatient Rehabilitation Facilities (IRF's) and or IRF units, as applicable pursuant to 42 U.S.C. 1395ww(d)(5)(F).

Medicare Disproportionate Share Hospital (DSH) Payment Background

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

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[5]

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.

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

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[6] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[7] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[8]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[9] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[10]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[11] and may terminate,[12] suspend[13] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[14] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[15]
2. The individual fails to apply for other benefits to which the individual may be entitled;[16]
3. The individual fails to participate in drug or alcohol addiction treatment;[17]
4. The individuals is absent from the United States for more than 30 days;[18] or
5. The individual becomes a resident of a public institutions or prison.[19]

[6] 42 U.S.C. § 1382.
[7] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[8] 20 C.F.R. § 416.202.
[9] 42 U.S.C. § 426.
[10] 42 U.S.C. § 426-1.
[11] 20 C.F.R. § 416.204.
[12] 20 C.F.R. §§ 416.1331-1335.
[13] 20 C.F.R. §§ 416.1320-1330.
[14] 20 C.F.R. § 1320.
[15] 20 C.F.R. § 416.207.
[16] 20 C.F.R. § 416.210.
[17] 20 C.F.R. § 416.214.
[18] 20 C.F.R. § 416.215.
[19] 20 C.F.R. § 416.211.

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[20]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[21] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[22] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[23] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[24] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[25]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[26]

---

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

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[27] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[28] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[29]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[30] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[31]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[32] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[33] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI

---

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

[27] CMS-1498-R at 5.

[28] *Id.*

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

[30] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

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

[32] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

[33] *Id.* at 50280.

benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[34] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[35] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[36]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[37] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[38] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[39]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[40]

As a result of the Rulings, new regulation and data match process, CMS either calculated new SSI percentages or recalculated existing SSI percentages for each of the Providers for all of fiscal years at issue in these appeals. 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).

---

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

Providers' Request for EJR

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

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

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

Decision of the Board

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

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

A. Dismissal of LIP Issue from Case No. 14-0735GC and the Status of the LIP Issue in Case Nos. 14-3797GC and 15-1145GC

The statement of the issue that accompanied the original hearing requests in Case No. 14-0735GC, 14-3797GC and 15-1145GC raised the following question concerning both DSH as it relates to IPPS providers ("IPPS/DSH providers") and LIP as it relates to IRF providers ("IRF/LIP providers"):

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

Case No. 14-0735GC covers fiscal year 2008 and the original Schedule of Providers filed with this case listed two providers – both IPPS/DSH providers and IRF/LIP providers.[45]

The LIP issue no longer remains in Case Nos. 14-3797GC and 15-1145GC because it was transferred from these appeals to two IRF/LIP group appeals, Case Nos. 17-1145GC and 17-0155G. Further, the Board dismissed these two IRF/LIP group appeals (*i.e.*, Case Nos. 17-1145GC and 17-0155G) on October 19, 2018 and December 14, 2018, respectively, finding that the Board lacked jurisdiction over the appeals for reasons substantially the same as those discussed in this decision.

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

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals for the District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* ("*Mercy*")[46] clarifies what is precluded from review in its analysis of this issue.

---

[44] (Emphasis added.)

[45] Each IRF/LIP provider receives its own unique provider number separate and apart from any associated IPPS/DSH provider. There is a "T" in the third digit of provider numbers assigned to IRF/LIP providers. For example in Case No. 14-0735GC, the two IPPS/DSH providers on the original Schedule of Providers were: (1) Good Shepherd Medical Center-Marshall (Prov. No. 45-0032); (2) Good Shepherd Medical Center-Longview (Prov. No. 45-0037). The associated IRF/LIP providers were 45-**T**032 and 45-**T**037, respectively.

[46] 891 F.3d 1062 (June 8, 2018).

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

2. Dismissal of the LIP Issue and any associated IRF/LIP providers from Case No. 14-0735GC

With respect to the LIP issue, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio, for IRF units. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Providers' appeal of the LIP adjustment dismisses that issue from the appeal.[50] In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent because the Providers could bring suit in the D.C. Circuit.[51] Finally, to the extent that the Amount in Controversy for Case No. 14-0735GC includes the LIP payments, those amounts would be inaccurately overstated as the LIP issue has been dismissed. As discussed below, the DSH/IPPS providers remain in Case No. 14-0735GC.

---

[47] *Id*. at 1064.
[48] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[49] *Mercy*, 891 F.3d at 1068.
[50] Moreover, even if the Board were to have jurisdiction over the LIP issue and the associated IRF providers, it is a separate legal issue (i.e., it is separate and distinct from the DSH issue for IPPS providers) and there can only be one issue in a group appeal. *See* 42 C.F.R. § 405.1837(a)(2).
[51] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

B. Jurisdictional Determination on the Remaining IPPS/DSH Providers

The remaining IPPS/DSH participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2008, 2010-2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending *prior to December 31, 2008*, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[52] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[53]

On August 21, 2008, new regulations governing the Board were effective.[54] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[55] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[56]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R ("Ruling 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under Ruling 1727-R, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest. The Board finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the

---

[52] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[53] *Bethesda* at 1258-59.
[54] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[55] 201 F. Supp. 3d 131 (D.D.C. 2016)
[56] *Banner* at 142.

Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases.

The Board has determined that the DSH/IPPS participants involved with the instant EJR request are from original NPR's and 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.[57] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying, remaining DSH/IPPS providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

C. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued Ruling 1498-R on April 28, 2010 to authorize remands of pending appeals of the SSI data match issue in order to recalculate the associated SSI fractions based on a revised data match process.[58] The Secretary also stated in the Ruling that, for those hospitals whose cost reports had not yet been settled, the Secretary would recalculate the SSI fractions for those cost reports using the revised data match process to be published through rulemaking.[59] Contemporaneous with Ruling 1498-R,[60] the Secretary published a proposed IPPS rule[61] to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the FY 2011 IPPS Final Rule in which the Secretary explained that:

> . . .we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[62]

---

[57] *See* 42 C.F.R. § 405.1837.
[58] CMS Ruling 1498-R at 27.
[59] *Id.* at 31.
[60] *Id.* at 5.
[61] 75 Fed. Reg. 23852, 24002-07.
[62] 75 Fed. Reg. at 50277.

Then she further announced:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[63]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[64]

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

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation.[65] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation the published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the IPPS/DSH Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility.[66] As a result, the Board finds that EJR is appropriate for the issue for the calendar years under appeal in these cases.

---

[63] (Medicare) Enrollment Database.
[64] 75 Fed. Reg. at 50285.
[65] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[66] The Board notes that the majority of the cases covered by this EJR request involve fiscal years beginning on or after October 1, 2010 and, as such, Ruling 1498-R is not applicable or relevant to the majority of the cases.

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

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

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

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

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

Board Members Participating:

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

For the Board:

4/2/2020

X Clayton J. Nix

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

However, there is one case that involves Ruling 1498-R, Case No. 14-0735GC where the Providers had a pre-10/1/2010 open cost report when Ruling 1498-R was issued and appealed from an original NPR. Notwithstanding, the Board notes that the Providers in this subset have *only* disputed the validity of the Uncodified SSI Data Matching Regulation which was finalized in the FY 2011 IPPS Final Rule and is applied to them via Ruling 1498-R as confirmed in the preamble to the FY 2011 IPPS Final Rule (75 Fed. Reg. at 50824-25) and have ***not*** raised any disputes or issues regarding the validity of Ruling 1498-R itself. *See* EJR request (including references to the Board's June 1, 2018 EJR determination in Case Nos. 13-1678GC, *et al.*); *compare* group appeal requests for all group appeals covered by this EJR decision. Accordingly, the Board finds that there are no unique 1498-R legal issues raised that would necessarily only pertain to Case No. 14-0735GC and, as such, that there are no substantive factual or legal differences among ***all*** of the cases covered by this EJR decision that would otherwise require the Board to bifurcate this EJR decision.

Enclosures: Schedules of Providers

cc: Justin Lattimore, Novitas Solutions
Danene Hartley, NGS
Cecile Huggins, Palmetto GBA
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

Manie Campbell
CampbellWilson, LLP
15770 North Dallas Pkwy, Ste. 500
Dallas, TX 75248

RE: ***Own Motion Expedited Judicial Review Determination***
13-1528GC The University of Texas 2007 SSI Part C Days CIRP Group
13-0996GC The University of Texas 2008 SSI Part C Days CIRP Group

Dear Mr. Campbell:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the two (2) above- referenced common issue related party ("CIRP") group appeals and, on February 7, 2020, 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 CIRP group 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]:

> SSI- Medicare Advantage Part C – Whether the Intermediary's audit adjustment related to Disproportionate Share Hospital ("DSH") Supplemental Security Income ("SSI") is proper.[2]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

[1] The Providers (filing in opposition to the EJR) and FSS, filed their responses to the Board on March 6, 2020, and March 9, 2020, respectively.
[2] Request for Hearing, Issue Statement, at Ex. 3 (Apr. 10, 2013), PRRB Case No. 13-1528GC; *See also* PRRB Case No. 13-0996GC.
[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).

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]

[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 Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered

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*

---

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.

---

[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. The Board seeks to rule 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 oppose the idea that since the Secretary has not acquiesced to the decision in *Allina I*, the Board remains bound by the regulation, thus the Provider opposes EJR.

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. Jurisdiction

The participants addressed in this EJR determination have filed appeals involving fiscal years 2007 and 2008.

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.

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.[37] The Board notes that the participant has one appeal stemming from a revised NPR included within this EJR (FYE 2007) that was issued after August 21, 2008.

1. <u>One Provider per Group Appeal and Closure of CIRP Groups</u>

Both Case Nos. 13-0096GC and 13-1528GC only have one participant in the group – University of Texas Southwestern Medical Center (Prov. No. 45-0044) ("UT Southwestern"). Specifically, on March 12, 2013, the designated representative filed the CIRP group appeal for the UT System chain for 2008 (assigned to Case No. 13-0996GC) and included UT Southwestern as the initial

[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. § 405.1889(b)(1) (2008).

and sole participant. Similarly, on April 10, 2013, the designated representative filed the CIRP group appeal for the UT System chain for 2007 (assigned to Case No. 13-1528GC) and again included UT Southwestern as the initial and sole participant.[38]

In a Request for Information letter send on January 16, 2020, the Board asked the following:

> On March 12, 2013, you filed the CIRP group appeal for the UT System chain for 2008 (assigned to Case No. 13-1528GC) and included UT Southwestern as the initial and sole participant. Similarly, on April 10, 2013, you filed the CIRP group appeal for the UT System chain for 2007 (assigned to Case No. 13-1528GC) and again included UT Southwestern as the initial and sole participant.
>
> Even though it has been more than 6 ½ years since you filed these CIRP appeals, the Board's electronic docket system shows that you have not added any other participants to either CIRP group and, as such, UT Southwestern remains the sole participant in both CIRP groups. Accordingly, ***within ten (10) days of the date of this letter (i.e., by Monday, January 27, 2020)****, you must advise the Board whether each of these two CIRP groups is fully formed. If one or both CIRP groups is not fully formed, you must identify which commonly owned Providers have not yet received a final determination for the specified fiscal year.* If you fail to respond by this deadline for one or both CIRP Groups, the Board will deem the relevant CIRP group(s) complete.[39]

The Provider failed to respond within the allotted time, and on January 27, 2020, the Board deemed the above groups complete, each with a single participant, and began to move forward with a potential own motion EJR.[40] *Further, the Board notes that, with the closure of these two CIRP groups, 42 C.F.R. § 405.1837(b)(1) acts to bar or prohibit the UT System Chain from pursuing the DSH Part C days issue for any other UT System Chain provider for the years covered by these two CIRP groups, i.e., 2007 and 2008.*

2. Jurisdiction for the Providers

For FY 2007, the Provider filed its appeal from a revised NPR which adjusted the SSI percentage as required by 42 C.F.R. § 405.1889 for Board jurisdiction. For FYE 2008, the Provider

---

[38] *Supra* note 1.
[39] (Emphasis in original.)
[40] In the Board's February 7, 2020 Notice of Own Motion EJR, the Board notified the Group Representative that "[t]he groups . . . have been deemed complete due to the Group Representative's failure to respond to the relevant portions of the Board's request for information dated January 16, 2020." The Group Representative filed its March 6, 2020 response to the Board's Notice of Own Motion EJR and this response did not challenge or otherwise discuss the Board's action to deem the two CIRP groups complete.

appealed from an original NPR in FYE 2008 and the Board has jurisdiction pursuant to *Bethesda* and CMS Ruling 1727-R as the Provider is challenging a regulation. ***Although both appeals were established as CIRP group appeals, each only has a single participant (i.e., UT Southwestern) and the Board is electing to treat these two CIRP group cases as individual appeals***. The participants' documentation shows that the estimated amount in controversy exceeds $10,000,[41] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Accordingly, the Board finds that it has jurisdiction for the referenced appeals and the participants.

Board's Analysis Regarding the Appealed Issue

The sole Provider in these two CIRP groups (*i.e.*, UT Southwestern) appealed the 2007 and 2008 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 FY 2008 IPPS final rule. The Board recognizes that, for the time periods at issue in these appeals, 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).[42] 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.[43]

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 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

[41] *See* 42 C.F.R. § 405.1837.
[42] *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).
[43] *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) 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. As the Board has granted EJR for the only issue in both groups, the appeals are hereby closed and removed from the Board's docket.

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:

4/3/2020

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Bruce Snyder, 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

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

RE: ***EJR Determination***

13-2800GC	UHS 2007 Dual Eligible Part C in DSH Medicaid Percentage Group
13-2828GC	UHS 2006 Dual Eligible Part C in DSH Medicaid Percentage Group
13-2845GC	UHS 2009 Dual Eligible Part C in DSH Medicaid Percentage Group
13-2897GC	UHS 2008 Dual Eligible Part C in DSH Medicaid Percentage Group
14-2707GC	UHS 2010 Dual Eligible Part C in DSH Medicaid Percentage Group
14-3589GC	UHS 2011 Dual Eligible Part C in DSH Medicaid Percentage Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 5, 2020 request for expedited judicial review ("EJR") for the six (6) common issue related party ("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]

---

[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. Instead, we are adopting a policy to include the patient days for 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 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 fraction had been vacated in *Allina I*.[27] The D.C. Circuit further found in *Allina II* that the

---

[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.

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 six (6) CIRP group appeals within this EJR request have filed appeals involving fiscal years 2007-2011.

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*").[29] In that case, the Supreme Court concluded that a cost report submitted in

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

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.

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 all of the participants involved with the instant EJR that filed appeals from original NPRs are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R as they are challenging a regulation. The remaining participants appealed from revised NPRs and had adjustments to Part C days as required for Board jurisdiction pursuant to

---

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. § 405.1889(b)(1) (2008).

42 C.F.R. § 405.1889. 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 all of 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 six (6) CIRP group appeals in these EJR requests involve the 2007-2011 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).[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) (2011) 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) (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 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
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

4/3/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Justin Lattimore Novitas Solutions
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

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***

16-1189GC	Emory Univ. Hosp. 2010 DSH SSI Part C Days Group
16-1447GC	Emory Univ. Hosp. 2011 DSH SSI Part C Days Group
17-2301GC	Emory Univ. Hosp. 2012 DSH SSI Part C Days Group
14-0221GC	Emory Univ. Hosp. 2008 DSH Medicaid Dual Eligible Days Part C Days Group
14-0556GC	Emory Univ. Hosp. 2009 DSH Medicaid Dual Eligible Days Part C Days Group
14-0575GC	Emory Univ. Hosp. 2007 DSH Medicaid Dual Eligible Days Part C Days Group
16-1190GC	Emory Univ. Hosp. 2010 DSH Medicaid Dual Eligible Days Part C Days Group
16-1448GC	Emory Univ. Hosp. 2011 DSH Medicaid Dual Eligible Days Part C Days Group
17-2302GC	Emory Univ. Hosp. 2012 DSH Medicaid Dual Eligible Days Part C Days Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 5, 2020 and March 9, 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

[1] Providers' EJR Requests at 1.

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

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

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

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

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

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

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

> 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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

---

[15] *Id.*

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

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

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

[19] 69 Fed. Reg. at 49099.

> *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]

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.

---

[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.

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 2007-2012.

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

[26] 863 F.3d 937 (D.C. Cir. 2017).
[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.

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 the participant revised NPR appeal included within this EJR request was issued after August 21, 2008.

---

[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. § 405.1889(b)(1) (2008).

A. Participant # 1 in Case No. 16-1447GC – Appeal of a Revised NPR with SSI Realignment

In Case No. 16-1447GC, Participant # 1 is Emory University Hospital Midtown (Provider No. 11-0078, FYE 8/31/2011) ("Emory Midtown"). Emory Midtown appealed its revised NPR that did not adjust the Part C issue as required for Board jurisdiction. Rather, it was an appeal of an SSI realignment.[35]

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

Emory Midtown requested that its SSI percentages be recalculated from the federal fiscal year to cost reporting year. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used.[36] The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the September 30 Federal fiscal year.[37]

The regulation, 42 C.F.R. § 405.1889 (2012), describes the limited rights that providers have to appeal *revised* determinations:

> (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 . . . 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.

[35] *See* PRRB Case No. 16-1447GC, Schedule of Providers and Jurisdictional Documents, Tab 1.A., The MAC's March 1, 2016 Notice of Reopening states that the cost report is being reopened "to adjust the SSI percentage to amount as recalculated by CMS using the provider's fiscal year of 09/01/2010-08/31/2011 and to adjust the [DSH] percentage to audited amount as a result of the change to the SSI percentage recalculated by CMS."

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

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

> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Since the revised NPR for Participant # 1, Emory Midtown, in Case No. Case No. 16-1447GC did not adjust the Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that it lacks jurisdiction over the revised NPR and hereby dismisses the appeal of the revised NPR for Emory Midtown from Case No. 16-1447GC. Notwithstanding, the Board notes that Emory Midtown also appealed its original NPR which will remain pending in Case No. 16-1447GC as discussed in the next subsection.

B. Jurisdiction and EJR for the Original NPR and Remaining Revised NPR Appeals

The Board has determined that, with the exception of the two (2) participants in Case No. 14-0575GC, all of the remaining participants involved with the instant EJR filed appeals from original NPRs and, as such, are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R as they are challenging a regulation. The two (2) remaining participants in Case No. 14-0575GC appealed from revised NPRs which had an adjustment to the Part C Day issue as required for Board jurisdiction. In addition, the remaining 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 for the above-captioned appeals and all of 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.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2007-2012 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).[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 Providers 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

[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).

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 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:

4/3/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Cecille Huggins, Palmetto
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

Felicia Sze, Esq.
Athene Law, LLP
5432 Geary Blvd, #200
San Francisco, CA 94121

Lorraine Frewert
Noridian Healthcare Solutions
Appeals Coordinator, JE Provider Audit
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Jurisdictional Decision***
Adventist Health Hanford (Prov. No. 05-0121)
FYE 12/31/2012
Case Nos. 18-1188, 19-0547

Dear Ms. Sze and Ms. Frewert,

The Provider Reimbursement Review Board (Board) has reviewed the above-captioned appeal in response to the Medicare Contractor's jurisdictional challenge. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

Adventist Medical Center - Hanford ("Hanford" or "Provider") appealed an Original Notice of Program Reimbursement ("NPR") dated October 12, 2017 for its fiscal year end (FYE) December 31, 2012 cost reporting period. On April 6, 2018, the Provider filed an individual appeal request which contained three issues:

1. The exclusion of approved per resident amount in the Graduate Medical Education ("GME") settlement;
2. The reduction of current and prior year resident counts due to a new education program commencing on July 1, 2005; and
3. The reduction in the inpatient prospective reimbursement rate in the budget neutrality adjustment for wage index rural floor.[1]

The Board assigned Case No. 18-1188 to this appeal. On December 28, 2018, the Provider withdrew Issue 3 concerning the budget neutrality adjustment.

On December 20, 2018, Hanford submitted a ***second*** appeal for the ***same*** FYE (December 31, 2012) but from a revised NPR. The Board assigned Case No. 19-0547 to this second appeal. The issue in Case No. 19-0547 is GME exclusion of current year, prior year, and penultimate

[1] Provider's Appeal Request, Tab 3.

year medical resident full time equivalent ("FTEs") as a result of the Medicare Contractor's failure to apply a per resident amount ("PRA") for FYE 12/31/2012.

On October 28, 2019, the Medicare Contractor submitted a Jurisdictional Challenge over the proper placement of the issue in Case No. 19-0547 as well as portions of Issues 1 and 2 in Case No. 18-1188. On November 26, 2019, the Provider responded to the jurisdictional challenge.

Medicare Contractor's Contentions:

A. GME Per Resident Amount and Exclusion of current year, prior year and penultimate year FTEs

The Medicare Contractor states that the Provider included the GME issue from Case No. 19-0547 in its Preliminary Position Paper for Case No. 18-1188 as "[I]ssue 4." The Medicare Contractor believes it would be appropriate for Case Nos. 18-1188 and 19-0547 to be consolidated for the GME PRA issue.

However, the Medicare Contractor notes that the issue statement for Issue 4 includes current year, prior year and penultimate year FTEs. The Medicare Contractor states that it did not adjust these on the revised NPR and that the Provider did not include discussion of these FTE counts in its preliminary position paper.

B. GME and IME Base Year Cap (portion of Issue 1 and Issue 2)

The Medicare Contractor challenges jurisdiction over the portions of Issue 1 (GME per resident amount) and Issue 2 (IME) current year and penultimate year FTE counts) in Case No. 18-1188.[2]

The Medicare Contractor is challenging jurisdiction over the GME Base Year Cap and IME Base Year Cap. The Medicare Contractor contends that the Provider did not include these issues in its Request for Hearing, nor were they timely added to the appeal.[3]

The Medicare Contractor asserts that the Provider is attempting to add the GME and IME Base Year Cap issues through the submission of its Preliminary position paper received January 2, 2019. The Medicare Contractor argues that the Request for Hearing included a discussion of Section 422 GME and IME FTE slots but this does not constitute an appeal of the original Base Year Caps.[4] The Medicare Contractor argues that this is a new issue that was not timely added to the Provider's appeal in accordance with 42 C.F.R. § 405.1835(e).[5]

The regulations for adding issues to a hearing request at 42 C.F.R. § 405.1835(e) states:

[2] Medicare Contractor's Jurisdictional Challenge at 2.
[3] *Id.*
[4] *Id.* at 4.
[5] *Id.* at 6.

> (e) Adding issues to the hearing request. After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if the following requirements are met:
>
> ***
>
> (3) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) of this section.

In accordance with these regulations, the deadline to add issues was June 2018. The Medicare Contractor asserts that the Provider first raised the additional GME and IME Base Year Cap issues in its Preliminary Position Paper received January 2, 2019.[6]

Provider's Contentions:

With respect to the GME IME base year cap (portion of Issues 1 and 2) in Case No. 18-1188, the Provider contends the Board should find jurisdiction over these issues pursuant to *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 403-04 (1988). The Provider states that the Board should deny the Medicare Contractor's challenge because it has met the requirements for an appeal. The Provider's request for hearing identifies dissatisfaction with a final determination of its NPR. The Provider's asserts that it identified base year in its appeal request.[7]

Relevant Statutes, Regulations and Board Rules

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

The subject appeal was filed with the Board in 2018 and the regulations required the following:

> (b) *Contents of request for a Board hearing.* The provider's request for a Board hearing under paragraph (a) of this subsection must be submitted in writing to the Board, and the request must include . . .
> (2) An explanation . . . of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal, including an account of…
> (i) Why the provider believes Medicare payment is incorrect for each disputed item . . . [and]

[6] *Id.*
[7] Provider's Jurisdictional Response at 5-8. (November 26, 2019)

> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[8]

Board Rule 8 (effective July 1, 2015) elaborates on this regulation requiring explanation of issues, stating:

> Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible…[9]

Analysis and Board Decision

A. GME and IME Base Year Cap (portion of Issue 1 and Issue 2) in Case No. 18-1188

The Provider's Issue Statement #1 in Case No. 18-1188 reads:

> Whether the Intermediary's adjustment number 31, the exclusion of the **base year** amount per resident, is in accordance with Regulation Section 413.86(e) which permits the Intermediary to re-audit **base year** amounts for a provider's approved residency educational program in order to establish an approved **base year** amount per resident and to properly reimburse Graduate Medical Education costs by including the current and prior year resident counts. The Intermediary has recognized the provider's residency program [and] audited and accepted the Provider's residency diskette… The Provider has lastly received CMS notification on October 27, 2005 that in accordance with Section 422 of Public Law 108-173 additional DGME and IME FTE slots were awarded to the hospital in their expansion of the residency program since 1996. However, the Intermediary has failed to reimburse the provider for current and prior year resident counts in the Graduate Medical Education reimbursement since there is no reimbursable **base year** amount per resident. (Emphasis added).[10]

Issue Statement #2 reads:

> Whether the Intermediary's adjustment number 18, the reduction of current and prior year resident FTE counts for the Indirect Medical Education computation, is consistent with the provider data to complete the Intern and Residents Information System

[8] 42 C.F.R. § 405.1835(b) (2018).
[9] Provider Reimbursement Review Board Rules, Rule 8 (2015), *available at* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRULES_07_01_2015.pdf
[10] Provider's Jurisdictional Response at 7 (November 26, 2019).

> (IRIS) in that the residents have been assigned to and are physically present at the Provider site and the Provider has incurred all of the costs for the residents which is consistent with documentation as supplied to the Intermediary by other providers and in accordance with 42 C.F.R. Regulation Sections 412.105 and 413.79.[11]

The Provider claims that its pending appeal relates to GME and IME base year caps. The Provider submitted its 2012 cost report without a Base Year Cap amount because the Base Year Caps had not yet been established. The Provider appealed Adjustments Nos. 18 and 31. Adjustment No. 18 states "To adjust Base Year Caps and Cap Adjustment." Adjustment No. 31 states "To adjust per resident amount since Base Year FTE count was not supported." While these adjustments do not specifically adjust GME and IME Base Year Caps, the Board concludes they are related and, therefore, finds that it has jurisdiction over the GME and IME Base Year Caps.

B. Consolidation of Case No. 19-0547 into Case No. 18-1188

The Board also finds that the issue in Case No. 19-0547 is related to the issue pending in Case No. 18-1188 and grants consolidation of Case No. 19-0547 into Case No. 18-1188. In this regard, the Board notes that the sole issue in Case No. 19-0547 (*i.e.*, GME PRA and exclusion of current year, prior year and penultimate year FTEs) is now Issue 4 in Case No. 18-1188 and that the Provider has already briefed this issue in its preliminary position paper filed in Case No. 18-1188. Accordingly, the Board hereby closes Case No. 19-0547 and Case No. 18-1188 remains open.

* * * * *

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

Board Members Participating:

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:

4/3/2020

X Clayton J. Nix

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

[11] Provider's Jurisdictional Response at 8 (November 26, 2019).

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Karen Kim
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520

John Bloom
Noridian Healthcare Solutions
P.O. Box 6722
Fargo, ND 58108

RE: ***Untimely Filing – Good Cause Exception***
Toyon Associates 2019 ATRA/MACRA Groups
Case Nos. 19-1147G, 19-1150GC, 19-1151GC, 19-1152GC, 19-1153G, 19-1154GC, 19-1156GC, 19-1158GC

Dear Ms. Kim and Mr. Bloom:

The Group Representative, Toyon Associates ("Toyon"), appealed its represented providers' Medicare reimbursement with the Provider Reimbursement Review Board ("Board"). The Group Representative requests that the Board accept its untimely appeals for the above eight (8) group appeals. As set forth more fully below, the Board has determined that good cause exists as to the untimely appeals made by the Providers participating in only four (4) of these groups.

Pertinent Facts:

By electronic submission dated Wednesday, February 13, 2019, the group representative submitted eight (8) *Request to Form Group Appeal* ("Request for Hearing" or "RFH") on the Office of Hearings Case and Document Management System ("OH CDMS") in order to establish group appeals as referenced above. These appeals are based on a Federal Register Notice ("the Notice") dated August 17, 2018. The groups were established ***exactly*** 180 days after the issuance of the Notice (*i.e.*, February 13, 2019 is the 180th day following August 17, 2018).[1]

On April 24, 2019, the Medicare Contractor noted that the deadline to file appeals of the Notice was February 13, 2019 and raised concern that there were allegedly no providers included in those groups as of February 13, 2019 filing deadline.[2] In this regard, the Medicare Contractor asserted that the first 12 providers were not added until February 14, 2019, the 181st day following August 17, 218. Accordingly, the Medicare Contractor maintains that all of the providers in the group appeals were added on an untimely basis and should be dismissed.[3]

[1] *See* Provider Request for Appeal, Case No. 19-1147G (Feb. 12, 2019); *See also* Case Nos. 19-1150GC, 19-1151GC, 19-1152GC, 19-1153G, 19-1154GC, 19-1156GC, 19-1158GC.
[2] *See* Medicare Contractor Review of Group Formation Document, Case No. 19-1147G (Apr. 24, 2019).
[3] *Id*.

On May 31, 2019, the Group Representative filed a response regarding its apparent untimely submission. The Group Representative maintains that they did attempt to timely add Providers to their appeals on February 13, 2019, 180 days after the issuance of the Notice; however, the Group Representative received a number of errors from the OH CDMS system.[4] As a result, the Group Representative contacted the OH CDMS help desk on February 13, 2019 after logging into the OH CDMS system and seeing that their attempts to add providers on February 13, 2019, was consistently resulting in errors.[5] The resulting Help Desk Ticket and associated assistance is attached as **Exhibit A**.[6]

Notwithstanding having reported the problem right away to the Help Desk, the Group Representative did continue to try and add providers.[7] However, the Group Representative maintains that they continued to experience problems with adding providers to the group via the online system *through the end of March 2019*.[8] The Group Representative recognizes that they were able to add providers to some groups starting on February 14, 2019, after previously unsuccessful attempts.

Review of the appeals in OH CDMS confirms that, for one appeal, the Group Representative successfully added two providers on the deadline date for filing, *i.e.*, on February 13, 2019.[9] The Group Representative filed seven (7) further appeals on February 13, 2019, in which the Medicare Contractor has challenged jurisdiction based on similar untimely addition of Providers to the appeals. In each of these appeals, the Group Representative claims similar errors as in the above appeal, all having occurred on the same February 13, 2019 date.

The record from the OH CDMS Help Desk (*see* Attachment A) demonstrates that, starting on February 13, 2019, the OH CDMS Help Desk worked with the Provider to resolve the reported issue and, in this regard, issued instructions to the Group Representative to permit third-party cookies in their web browser. On March 5, 2019, the OH CDMS Help Desk notified the Group Representative that it considered the incident resolved as the Help Desk was unable to replicate the issue.[10]

In addition, OH CDMS records document the following with regard each appeal and the direct addition of providers to those appeals:

---

[4] *See* Provider Response to Medicare Contractor Review (May 21, 2019).
[5] *Id*.
[6] The OH CDMS Help Desk opened Ticket 562 to track the issue and include the emails sent to the caller, summaries of phone calls, and development notes (hereinafter "Help Desk Ticket"), attached as Exhibit A.
[7] *Id*.
[8] *See* Provider Response to Medicare Contractor Review at 1.
[9] Group Participants 1 and 2, Providers 05-0145 and 05-0276, appear in the system to have been added timely, on Feb. 13, 2019.
[10] *Id*.; The Help Desk could not replicate the issue, and recommended a course of action for future issues related to this incident, *See* Exhibit A, at 5.

A. Case No. 19-1147G – RFH filed 2/13/2019

On Feb. 13, 2019, the Group Representative used OH CDMS to establish Case No. 19-1147G and, on the same day, also ***timely*** directly added the following 2 providers to this group:

1. Community Hospital of the Monterey Peninsula (05-0145); and
2. Contra Costa Regional Medical Center (05-0276).

On February 14, 2019, the Group Representative used OH CDMS to directly add the remaining 13 providers to Case No. 19-1147G.

B. Case Nos. 19-1150GC & 19-1151GC – RFH filed 2/13/2019

On February 13, 2019, the Group Representative used OH CDMS to establish Case Nos. 19-1150GC and 19-1151GC. The Group Representative did not directly add any providers to these cases until February 15, 2019 at which time all the providers for these cases were directly added.

C. Case No. 19-1152GC – RFH filed 2/13/2019

On February 13, 2019, the Group Representative used OH CDMS to establish Case No. 19-1152GC. The Group Representative did not directly add any providers to this case until more than a month later on March 22, 2019 at which time all the providers for this case were directly added.

D. Case No. 19-1153G – RFH filed 2/13/2019

On February 13, 2019, the Group Representative used OH CDMS to establish Case No. 19-1153GC. The Group Representative did not directly add any providers to this case until February 14, 2019. All providers in this group were directly added on February 14 and 15, 2019.

E. Case No. 19-1154GC – RFH filed 2/13/2019

On February 13, 2019, the Group Representative used OH CDMS to establish Case No. 19-1154GC. The Group Representative did not directly add any providers to this case until more than a month later on March 21, 2019 at which time all the providers for this case were directly added.

F. Case Nos. 19-1156GC & 19-1158GC– RFH filed 2/13/2019

On February 13, 2019, the Group Representative used OH CDMS to establish Case Nos. 19-1156GC and 19-1158GC. The Group Representative did not directly add any providers to these case until more than a month later on March 21, 2019 at which time all the providers for these cases were directly added.

Board's Determination

The Board's enabling statute at 42 U.S.C. § 1395oo(a)(3) requires an appeal be filed "*within 180 days after notice of the . . .Secretary's final determination.*"[11] Similarly, pursuant to 42 C.F.R. § 405.1835(a)(3), the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination unless, pursuant to 42 C.F.R. § 404.1836, a Provider qualifies for a good cause extension. Here, the Providers appealed a Federal Register Notice which was the Secretary's final notice of the IPPS rates for the Federal fiscal year 2019. As explained below, a provider is presumed to receive Federal Register Notices upon their publication and, as such, the deadline for filing an appeal of a Federal Register Notice is 180 days from the publication date of that notice.

The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[12] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[13] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, sections 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[14] of the Social Security Act [relating to disclosure of information] as it applies to [CMS]. . . [and] (2) Relate to the availability to the public, under 5 U.S.C. § 552,[15] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, *requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice*. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
>
> (E) each amendment, revision, or repeal of the foregoing.

[11] (emphasis added).
[12] *See* 42 C.F.R. § 405.1867.
[13] of the Department of Health and Human Services.
[14] 42 U.S.C. § 1306(a).
[15] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act (FOIA).

In order to comply with the statutes and regulations requiring that public notice be given, CMS publishes the schedules of the Prospective Payment System (PPS) rates in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). This regulation was created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[16]

With regard to the notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[17]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office ("GPO") promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet on the GPO website.[18] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[19] Consequently, ***the Provider is deemed to have notice of the standardized amount on the date the Federal Register was published and made available online***.[20]

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[21]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: the date of publication of the Federal Register is the date the Providers are deemed to have notice of

---

[16] *See also* 42 C.F.R. Part 401, Subpart B.

[17] (Emphasis added.)

[18] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).

[19] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.

[20] While there is the official publication date (*e.g.*, the official publication date of the FY 2019 IPPS final rule is August 17, 2018), it is the Board's understanding that the GPO (or the sponsoring agency) may post a copy of a rulemaking several days in advance of the official publication date. The Board considers the official publication date as the official notice to the public and, as such, 180-day clock starts from the official publication date regardless of whether it may have been posted in advance.

[21] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).

the IPPS rules including the Standardized Amount. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office. Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents. This is reflected in Board Rule 4.3.2 which states:

> The date of receipt of a Federal Register Notice is *the date the Federal Register is published*. The appeal period begins on the date of publication and ends 180 days from that date.

As a result, each of the Providers in the above-captions group appeals needed to file its hearing request within 180 days of the publication of the Federal Register notice. In these eight (8) group appeals, the 180th day fell on February 13, 2019. While the Group Representative established these group appeals on the February 13, 2019 filing date, the Group Representative did not add any of the provider across these eight (8) group appeals by this deadline except for two providers in Case No. 19-1147G. Accordingly, for the *remaining* providers, the question becomes whether the Group Representative has established good cause to warrant extension of this time limit in accordance with 42 C.F.R. § 405.1836.

In its response to the Medicare Contractor's challenge, the Group Representative asserts that the groups were untimely filed:

> [T]he Board's rules provide for the fact that groups may be formed with no providers, at least initially. The "Commentary" in the Board Rules for Rule 12.2 specifically states that "if a group is to be formed solely through transfers, it may initially be established in OH CDMS with no participating providers." While this case involved direct additions of providers, rather than transfers, clearly the Board acknowledges that groups are able to be formed without providers, and the Board did not say such groups would be considered improperly initiated until providers were added.[22]

However, the Board finds that the Group Representative made an incomplete analysis of Board Rules. In this regard, the Board notes that Board Rule 12.6 simply addresses the number of Providers required establish a group. In connection with CIRP groups, Board Rule 12.6.1 states that: "[a] CIRP group may be initiated by a single provider under common ownership or control, but at least two different providers must be in the group upon full formation."[23] Similarly, in connection with optional groups, Board Rule 12.6.2 states that: "[o]ptional group appeals must

[22] *See* Providers' Response to Medicare Contractor Review at 2.
[23] PRRB Rule 12.6.1 (Aug. 29, 2018).

have a minimum of two different providers, both at inception and at full formation of the group."[24] These Board Rules do not (and cannot) alter the statutory and regulatory requirement that each provider participating within a group must meet the 180-day filing requirement. In this regard, Board Rule 16.2.1 states:

> Direct add requests submitted through OH CDMS may be initiated in conjunction with a new group appeal request or within an existing group. *The request must include the same information required for a provider filing* ***an individual appeal***, including the determination and issue-specific information addressed in Rule 7, plus a copy of the representative letter associated with the group appeal.[25]

Further, the Board notes that the Group Representative failed to recognize in its analysis the remaining content of the Commentary to Board Rule 12.1 which states the following:

> Accordingly, if a group is to be formed *solely through transfers*, it may initially be established in OH CDMS with no participating providers. In such cases, the *providers* ***must*** *be transferred immediately following the establishment of the group case in order to fulfill the regulatory requirement for the minimum number of providers* per Rule 12.6. The Board will close all group cases that do not meet the minimum participant requirements.[26]

With regard to a good cause extension, 42 C.F.R. § 405.1836(b) (2008), states in pertinent part:

> The Board may find good cause to extend the time limit only if the provider demonstrates in writing it *could not reasonably be expected to file timely due to extraordinary circumstances beyond its control* (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit….[27]

As noted above, the Providers filed correspondence along with the various Requests For Hearing noting that they completed and submitted the online application for all the above mentioned appeals on February 13, 2019, but were unable to add at least one provider in all but one appeal on that same day.[28] The Group Representative claims that, when they attempted to directly add

---

[24] *Id*. at Rule 12.6.2.
[25] (Empahsis added.)
[26] PRRB Rule 12.1 Commentary (emphasis added).
[27] 42 C.F.R. § 405.1836(b) (emphasis added).
[28] Providers' Response to Medicare Contractor Jurisdictional Review, PRRB Case No. 19-1147G, *et al.*

the Providers, OH CDMS malfunctioned and did not allow them to add the providers.[29] The Group Representative has submitted to the Board the "incident" ticket from the OH CDMS help desk, dated February 13, 2019.

In addition to reporting the problem immediately to the Help Desk on February 13, 2019, the Group Representative claims that they continued to try and add providers unsuccessfully for the most part. As previously noted, the OH CDMS Help Desk immediately assisted the Group Representative and, following this help, notified the Group Representative on March 5, 2019 that it considered the Group Representative's incident resolved after the Help Desk was unable to replicate the issue. Significantly, the records establish that following the Help Desk's March 5, 2019 notice, the Group Representative did not contact the Help Desk with any other issues.

Notwithstanding, the Group Representative claims to have experienced continued problems with adding providers to the group via the online system *through the end of March 2019*. In this regard, the Group Representative insists that it directly added all of the providers to each of the above-captioned groups *as soon as possible* once the computer issues were resolved and they could get the system to work. They claim that any purportedly untimely addition of providers to this group appeal was not their fault and to hold them responsible as such would be extremely prejudicial and inequitable.[30] Finally, the Group Representative provided an email noting previous systems issues that they had with OH CDMS.

In reviewing the record, the Board notes that the Group Representative directly added the providers to each respective group appeal essentially within two different clusters. One cluster was directly added within 0-2 days after the filing deadline while the other cluster was done much later, 36 to 37 days after the filing deadline. More specifically, for one half of the groups, the Group Representative directly added providers on or within 48 hours of the filing deadline (*i.e.*, February 13 and 15, 2019) and, for the other half, the Group Representative directly added the providers between March 21 and 22, 2019 which is more than a month after the February 13, 2019 filing deadline and more than two weeks after the Help Desk notified the Group Representative that its OH CDMS issue had been resolved.

The Board finds that March 5, 2019 is the inflection point for the Provider's request for good cause exception because this is the date that the Help Desk reported that the Group Representative's filing issue had been resolved and because, subsequent to that date, the Group Representative did not report ***any*** continued filing difficulties to the Help Desk. Accordingly, the Board finds that the Group Representative has established good cause for those direct adds that were made prior to March 5, 2019 when the Help Desk Ticket was closed and that there is no good cause to excuse untimely filing for the providers that directly added after March 5, 2019 because such providers were directly added ***well after*** the Help Desk Ticket was closed on March 5, 2019. Specifically, after reviewing the filing dates of each provider, the Board makes the following findings with respect to each of the eight (8) group appeals:

---

[29] *Id*.
[30] Provider's Response to Medicare Contractor Jurisdictional Review, PRRB Case No. 19-1147G, *et al.*

A. For Case No. 19-1147G, the Group Representative timely filed direct adds for two providers (Community Hospital of the Monterey Peninsula (05-0145) and Contra Costa Regional Medical Center (05-0276)) and has established good cause for the remaining providers that were directly added to this case since these remaining providers were directly added well ***prior to*** March 5, 2019 when the OH CDMS Help Desk notified the Group Representative that the February 13, 2019 Incident had been resolved.

B. For Case Nos. 19-1150GC, 19-1151GC, and 19-1153G, the Group Representative has established good cause since all of the providers for these groups were added well ***prior to*** March 5, 2019 when the OH CDMS Help Desk notified the Group Representative that the February 13, 2019 Incident has been resolved.

C. For Case Nos. 19-1152GC, 19-1154GC, No. 19-1156GC, and 19-1158GC, the Group Representative has not established good cause since all of providers for these groups were added ***well after*** March 5, 2019 when the OH CDMS Help Desk notified the Group Representative that the February 13, 2019 Incident has been resolved and after which date the Group Representative did not have any active inquiry or ticket with the Help Desk.

Accordingly, the Board hereby dismisses the appeals and closes Case Nos. 19-1152GC, 19-1154GC, 19-1156GC, and 19-1158GC pursuant to Board Rule 12.6 and 42 C.F.R. § 405.1836(b). The Board concludes that there is good cause for the Group Representative's untimely filing of providers to the remaining appeals, 19-1147G, 19-1150GC, 19-1151GC, and 19-1153G and, accordingly, these cases will remain open and continue in due course before the Board.

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
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

4/3/2020

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Daniel J. Hettich, Esq.
King & Spalding, LLP
1700 Pennsylvania Ave., NW
Washington, DC 20006-4706

RE: ***EJR Determination***
South Lake Hospital (Prov. No. 10-0051)
FFY 2020
Case No. 20-1173

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's February 12, 2020 request for expedited judicial review ("EJR") and its March 11, 2020 response to the Board's March 9, 2020 request for additional information for the above-referenced appeal. The Board asked whether the Provider should be included in a mandatory group appeal because it was commonly owned by Orlando Health. The Provider explained that the other hospitals in the Orlando Health organization were not impacted by treatment of Section 401 hospitals because they had been reclassified as rural hospitals and were not impacted by Federal Register policy discussed in more detail below. The decision of the Board regarding EJR is set forth below.

The issue for which EJR has been requested involves:

> The Provider . . .challeng[es] [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]

[1] of the Department of Health and Human Services.
[2] Provider's 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).

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"). 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]

---

[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).

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"), 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***

[11] H.R. Rep. No. 105-149, at 1305 (1997).
[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)) 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 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

[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).

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 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

[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.
[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)

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 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 two policies:

1. The policy "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)";[31] and

2. The policy, "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 [42 U.S.C. § 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 [42 U.S.C. § 1395ww](d)(8)(C)(iii)]."[32]

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

---

[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.
[32] *Id.*

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

In the FFY 2020 IPPS proposed rule,[33] 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.[34] 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.[35]

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.[36]

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.[37]

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.

[33] 84 Fed Reg. 19158, 19396-8 (May 3, 2019).
[34] 84 Fed. Reg. at 42333, 42336.
[35] *Id.* at 42333.
[36] *Id*.
[37] *Id.* at 42334.

§ 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 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.[38]

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.[39]

Providers' Position

The Provider explains 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).[40] In the FFY 2020 IPPS final rule, the Provider contends 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 Provider contends that the new wage index rule is unlawful because it conflicts with the requirements of the Medicare statute.

The Provider objects 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)."[41] 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 Provider asserts 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 Provider contends 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 Provider argues 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

[38] *Id.*
[39] *Id.*
[40] BBA § 4410(a) (available at 42 U.S.C. § 1395oo note).
[41] 84 Fed. Reg. at 42336.

being located in the rural area. . .of the State in which the hospital is located"[42] And BBA § 4410(a) specifies that the wage index for hospitals in a state "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." The Provider asserts 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 Provider believes that the Secretary's interpretation is unlawful because it violates the statute and is not based on a reasonable interpretation of the statute. The Provider contends 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 Provider reimbursement that it withheld as a result of that regulation.

Decision of the Board

The participant within this EJR request has filed an appeal involving FFY 2020 based on its appeal from the FFY 2020 IPPS final rule.

A. Jurisdiction and Request for EJR

As previously noted, the Provider appealed from the FFY 2020 IPPS final rule.[43] The Board has determined the participant's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal.[44] The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal 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.

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

The Board notes that the relevant *cost reporting period(s)* for this participant 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.[45] However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether the relevant Provider's cost report(s)

---

[42] 42 U.S.C. § 1395ww(d)(8)(E)(1).
[43] 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).
[44] *See* 42 C.F.R. § 405.1835.
[45] *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015).

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.[46]

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.[47] Specifically, in the preamble to FFY 2020 IPPS final rule, the Secretary announced the following two policies to address wage index disparities:

1. The policy "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)";[48] and

2. The policy, "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 [42 U.S.C. § 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 [42 U.S.C. § 1395ww](d)(8)(C)(iii)]."[49]

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

[46] *See* 80 Fed. Reg. at 70556, 70569-70.
[47] *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").
[48] 84 Fed Reg. at 42336.
[49] *Id.*

> 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 index for rural areas in the State in which the county is located’’ referred to in section [1395ww](d)(8)(C)(iii). . . .[50]

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."[51]

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.

D. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the 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.

---

[50] *Id.*

[51] 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 . . . ."

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

Board Members Participating:

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

FOR THE BOARD:

4/3/2020

X Clayton J. Nix

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

cc: Geoff Pike, First Coast Service Options
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

Ms. Rhonda Houchens
Hargis & Associates
186 N. Main Street
Russellville, KY 42276

RE: ***Dismissal Due to Untimely Filing of Appeal***
The Cottages of Clayton (Prov. No. 26-0351)
FYE 12/31/2018
Case No. 20-1358

Dear Ms. Houchens:

On March 6, 2020, the Provider filed an appeal request with the Provider Reimbursement Review Board ("Board") to which the Board has assigned Case No. 20-1358. The filing indicates that the appeal is based on the Notice of Program Reimbursement ("NPR") dated July 10, 2019 for the Provider's fiscal year ending ("FYE") December 31, 2018. As Set Forth below, the Board is dismissing the appeal as it was not timely filed.

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

Board Rule 4.3.1 states, in part:

> The date of receipt of a contractor final determination is presumed to be 5 days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).
>
> The appeal period begins on the date of receipt of the contractor final determination as defined above and ends 180 days from that date.

Board Rule 4.5.A states, in part:

> Timely filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be:

A. The date submitted to OH CDMS as evidenced by the Confirmation of Correspondence generated by the system.

Board Decision:

The Board notes that the final determination in dispute is an NPR dated July 10, 2019. Pursuant to the Board Rules and regulations cited above, the Provider is presumed to have received the NPR five days later, *i.e.*, on July 15, 2019. The timeframe for filing an appeal is 180 days from the date receipt which was Saturday, January 11, 2020 (*i.e.*, 180 days from July 15, 2019). As January 11, 2020 was a Saturday, the deadline was the next business day, *i.e.*, Monday, January 13, 2020. The subject appeal was submitted to the Board on March 6, 2020 which is 53 days after the January 13, 2020 filing deadline. Accordingly, the Board concludes that the appeal was not timely filed in accordance with the statute, regulations, and Board Rules and hereby dismisses the appeal in its entirety from Board consideration. 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
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

4/3/2020

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services
Judith Cummings, CGS Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Cecile Huggins, Appeals Manager
Provider Cost Report Appeals
Palmetto GBA (J-J)
Internal Mail Code 380
P.O. Box 100307
Camden, SC 29202-3307

Re: ***Wellmont Bristol Regional Medical Center*** *(Prov. No. 44-0012, FYE 06/30/2008)*
Case No. 13-2603

Dear Mr. Ravindran and Ms. Huggins:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject appeal in response to the Representative's January 20, 2020 reinstatement request. The background of the case and the Board's determination are set forth below.

Background:

On August 6, 2013, Quality Reimbursement Services, Inc. ("QRS") filed the individual appeal for Wellmont Bristol Regional Medical Center (the "Provider"). The initial appeal included 7 issues: DSH SSI Provider Specific; DSH SSI (Systemic Errors); DSH Medicaid Eligible Days; DSH Medicare Managed Care Part C Days; DSH Dual Eligible Days, DSH Medicaid Eligible Labor Room Days and Outlier Payments – Fixed Loss Threshold.

On March 6, 2014, QRS transferred the following issues to groups:

Issue	Group Case
Outlier Payments – Fixed Loss	14-0399GC
SSI Percentage	14-0404GC
SSI Fraction Dual Eligible Days	14-0405GC
Medicaid Fraction Dual Eligible Days	14-0408GC
SSI Fraction Managed Care Part C Days	14-0409GC
Medicaid Fraction Managed Care Part C Days	14-0411GC

On May 23, 2014 the Medicare Contractor filed a jurisdictional challenge over the DSH SSI Provider Specific issue and the DSH Medicaid Eligible Days issues. With regard to the SSI Provider Specific issue, the Medicare Contractor contends that the issue is premature as the Provider had not yet submitted a request for recalculation so there has been no formal determination as required under 42 CFR § 405.1835.[1]

[1] Medicare Contractor Jurisdictional Challenge (May 21, 2014) at 2.

On June 20, 2014, QRS filed a Jurisdictional Response in which it argued that it was ". . . not only addressing a realignment of the SSI percentage, but also addressing various errors of omission and commission that do not fit into the "systemic errors" category." QRS went on to explain that, because the Medicare Contractor made an adjustment to the SSI Percentage and because it is dissatisfied with the DSH payments for the year under appeal, the issue is appealable. The arguments in support of this related to the Provider's lack of access to the MEDPAR data and to the *Baystate Medical Center v. Leavitt* case.[2]

On January 8, 2020, QRS withdrew the Medicaid Eligible Days issue to facilitate a reopening of the issue with the Medicare Contractor. On January 9, 2020, the Board processed the withdrawal of the Medicaid Eligible Days issue and closed the case on January 9, 2020 as it appeared all issues had been transferred to groups or had been withdrawn.

On January 22, 2020, QRS requested reinstatement of the subject individual because there still was still one issue pending in the appeal following the January 8, 2020 withdrawal, namely the SSI Provider Specific issue.

Board Determination:

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

The Board finds that, as pointed out by QRS, there was a remaining issue when the Board processed the withdrawal and closed the case on January 9, 2020. Therefore, the Board hereby reinstates the subject case for the sole remaining issue – the SSI Provider Specific issue.

With regard to the SSI Provider Specific issue, the regulation at 42 C.F.R. § 412.106(b)(3), permits a Provider to request that CMS use its cost reporting period instead of the Federal fiscal year in calculating the SSI percentage of the DSH payment calculation. The Provider must make such a request in writing to its Medicare Contractor.

The SSI Provider Specific issue statement in the subject case indicates that the Provider disagrees with the calculation of the DSH percentage because the SSI percentage published by CMS was incorrectly computed without including patients entitled to SSI benefits in the calculation. Further, the Provider states the appeal of this issue was filed to preserve ". . . its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[3]

[2] Representative's Jurisdictional Response (June 18, 2014) at 1.
[3] Provider's Appeal Request (Aug. 5, 2013) Tab 3 at 1.

The first aspect of the SSI Provider Specific issue involves the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage. This Board finds this issue to be duplicative of the SSI Systemic Errors issue that was transferred to Case No. 14-0404GC. In this regard, the Board notes that the group appeal issue statement for Case No. 14-0404GC is inclusive of the Provider's statement of the SSI Provider Specific issue as evidenced by the following excerpts from the group appeal issue statement:

> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records, . . .
> 3. Not in agreement with provider's records, . . .
> 4. Fundamental problems in the SSI percentage calculation, ...

Therefore, the Board dismisses this aspect of the SSI Provider Specific issue from Case No. 13-2603.

The second aspect of the SSI Provider Specific issue, involves the Provider's "realignment" election to CMS to use its cost reporting period instead of the Federal fiscal year to calculate the SSI percentage of the DSH calculation (*i.e.*, "realign" the SSI percentage to its cost reporting period). Since there is no evidence in the record that the Medicare Contractor has made a final determination (or that the Provider has even requested a change from CMS), the Board finds this aspect of the issue to be premature and that the Board does not have jurisdiction over it.

In summary, following the reinstatement of Case No. 13-2603 for the sole remaining issue, the SSI Provider Specific issue, the Board finds that it contains two parts—one which is duplicative of an issue already transferred to Case No. 14-0405GC and the other over which the Board has no jurisdiction. As there are no issues remaining, the Board closes Case No. 13-2603. Review of the jurisdictional 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:
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

4/9/2020

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Daniel Hettich, Esq.
King & Spalding, LLP
1700 Pennsylvania Avenue NW
Washington, DC 20006

RE: ***Denial of Motion for Reinstatement***
Lakeland Regional Health
FYE 9/30/07
Case No. 13-2953

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") is in receipt of your letter dated December 11, 2019 in which you asked the Board to reconsider its jurisdictional dismissal dated November 20, 2019 and reinstate the case. In its jurisdictional dismissal, the Board found that the Provider failed to develop its case as required by the regulations and the Board Rules. As such, the Board concluded that the Provider violated Board Rule 25 and 42 C.F.R. § 405.1853(b)(2) because the Provider's Final Position Paper ("FPP") did not set forth the relevant facts and arguments regarding the merits of the Provider's claims. Set forth below is the Board's decision to deny the Provider's Motion for Reinstatement.

Provider's Motion for Reinstatement

The Provider explains that, on July 1, 2019, the Board issued a Notice of Hearing for this case which set a deadline of September 18, 2019 for the Provider to submit its FPP to the Board. On August 30, 2019, the Provider submitted an unopposed request to stay the appeal for one year pending the outcome of *Pomona Valley Hosp. Med. Ctr. v. Azar* ("*Pomona Valley*") that was filed in the D.C. District Court on November 27, 2018[1] because that case is challenging the same legal issue – namely the lingering systematic errors in CMS's SSI matching process – and is pending in the D.C. District Court where all providers have recourse to bring suit. Having not heard from the Board on its request to stay the appeal, the Provider timely submitted its FPP on September 17, 2019 in compliance with the deadline set in the Notice of Hearing.

The Provider asks the Board to reinstate the case in light of the fact that the Provider submitted a request to stay the case on August 30, 2019. The Provider maintains that, although its request to stay the case one year was not expressed as a request for an extension on the deadline to file its FPP, it should have been treated as a request to extend the Final

[1] No. 18-02763 (D.D.C. filed Nov. 27, 2018).

Position Paper deadline by one year as well. In this regard, the Provider emphasizes that, in footnote 12 of the Board's jurisdictional dismissal, the Board noted that the Provider could have requested an extension to the Final Position Paper deadline, but did not make such a request.

The Provider states that it had good cause *to request the stay* pending the outcome of *Pomona Valley*. In *Pomona Valley*, the plaintiff hospital has alleged systematic errors in the SSI matching process. If the plaintiff hospital is successful in D.C., the outcome will be extremely relevant to Lakeland because it has recourse to file its appeal in D.C. District Court. Furthermore, the errors in CMS' data matching process that the plaintiff in *Pomona Valley* identified would probably apply to other providers such as Lakeland.

The Provider goes on to state that, additionally, the best evidence that Lakeland could present to make its case is the SSI data maintained by the Social Security Administration, which the government has categorically refused to make available to providers. It would be perverse to dismiss Lakeland's appeal for failing to provide data that the agency specifically refuses to provide since it would reward the agency for its own intransigency.

The Provider notes that, in the absence of SSI data, the best available alternative is Medicaid data. In many states, including Florida, residents are automatically eligible for Medicaid benefits if they receive SSI benefits. The Social Security Administration supplies these states with data regarding residents who are SSI beneficiaries. The Provider believes that it could obtain this data from Florida and use it to determine its correct SSI percentage.

Finally, the Provider goes on to note that it is both willing and able to incur the costs associated with obtaining and analyzing the SSI data from Florida Medicaid if that evidence is sufficient to show that the SSI percentage used by the Medicare Contractor is understated. In this regard, the Provider maintains that this is precisely the question that is before the D.C. District Court in *Pomona Valley*. If the D.C. District Court finds that the Medicaid data that the plaintiff used to reconstruct its SSI/Medicare fraction is sufficient to demonstrate that the SSI percentage was inaccurate, then the Provider will consider investing the resources to obtain and analyze the data from Florida Medicaid.

In light of the above, the Provider asks the Board to reinstate its appeal and to grant the Provider's request for a one-year stay pending the outcome of *Pomona Valley*.

Board's Decision

As set forth below, the Board is denying the Provider's motion for reinstatement.

The Notice of Hearing set the September 18, 2019 filing deadline for the Provider's FPP and describe it as follows:

> Provider's Final Position Paper – For each remaining issue, the position paper must state the **material** facts that support the appealed claim, **identify the controlling authority** (e.g., statutes, regulations, policy, or case law), and provide arguments applying the **material** facts to the controlling authorities. This filing must also include any exhibits the provider will use to support its position. *See* **Board Rule 27 for more specific content requirements**.[2]

In this regard, with respect to position papers, the regulations at 42 C.F.R. § 405.1853(b)(2) state the following:

> Each position paper *must set forth the relevant facts* and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal, *and the merits* of the provider's Medicare payment claims for each remaining issue.[3]

Board Rule 27 incorporates the requirements for preliminary position papers as delineated in Board Rule 25. In this regard, these Rules state the following, in pertinent part:

> **Rule 27 Final Position Papers**
>
> ****
>
> 27.2 Content
>
> The final position paper should address each remaining issue. *The minimum requirements* for the position paper narrative and exhibits *are the same as those outlined for preliminary position papers at Rule 25*.[4]
>
> **Rule 25 Preliminary Position Papers**
>
> 25.1 Content of Position Paper Narrative
>
> The text of the position papers *must* contain the elements addressed in the following subsections.
>
> 25.1.1 Provider's Position Paper
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, *state the material facts that support the provider's claim.*

[2] (Emphasis added and footnote omitted.)
[3] (Italics emphasis added.)
[4] (Italics emphasis added.)

> C. *Identify the controlling authority,* (e.g. statutes, regulations, policy or, case law) *supporting the provider's position.*
>
> D. *Provide a conclusion applying the material facts to the controlling authorities*.
>
> 25.2 Position Paper Exhibits
>
> 25.2.2 Unavailable and Omitted Documents
>
> *If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available*.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. . . .
>
> 25.3 Filing Requirements to Board
>
> Parties should file with the Board a **complete** preliminary position paper with *a fully developed narrative* (Rule 23.1), *all* exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.[5]

Finally, the regulations at 42 C.F.R. § 405.1868 state the following:

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

[5] (Italics and underline emphasis added.)

Board Rule 47 addresses reinstatements and specifies in Board Rule 47.1 that a provider may file a written motion for reinstatement within three years of from the date of the Board's decision to dismiss the issue(s)/case. Board Rule 47.1 further explains that the motion must include the reasons for reinstatement and sets forth the general rule that the Board will not reinstate a case if the provider was "at fault." Additional guidance pertinent to this case is located in Board Rule 47.3. This Rule addresses reinstatement requests involving dismissals for failure to comply with Board procedures and specifies that: (1) "[u]pon written motion demonstrating ***good cause***, the Board may reinstate a case dismissed for failure to comply with Board procedures;"[6] and (2) "[g]enerally, ***administrative oversight***, settlement negotiations, or a change in representative will not be considered good cause to reinstate."[7]

At the outset, the Board notes that, contrary to the Provider's suggestion, the Provider's August 30, 2019 request for a stay or abeyance did not discuss or address its obligation to file the FPP (or, in particular, its ability or inability to meet the content requirements as summarized at Board Rule 25.3). Indeed, the request for abeyance recognized that the Board has previously denied other similar requests involving pending litigation and, accordingly, the Provider later filed the FPP consistent with the Board's guidance in Board Rule 23.6 as the Board had not yet ruled on the Provider's request for abeyance by the due date of the Provider's FPP. Specifically, Board Rule 23.6 is entitled "Miscellaneous Motions Filed ***Prior to*** PJSO or ***Position Paper Deadline***" and states:

> ***Pending requests*** (such as transfers, *requests for abeyance*, expedited judicial review, mediation, jurisdictional challenges, discovery, or other motions), until complete or ruled on favorably by the Board where applicable, ***will not suspend these filing requirements***. If a motion or request is not complete or has not been ruled on, *you must proceed as if it will not occur or will not be granted*.
>
> If an issue is not timely addressed as required in this rule because the parties have relied on an incomplete action or a pending request that is not yet ruled on, it is subject to dismissal at any time during the proceedings.[8]

However, as thoroughly discussed in the Board's November 20, 2019 determination, the Provider's FPP itself was deficient because the Provider failed to develop its case in the FPP in compliance with Board Rules governing the filing requirements for position papers. [9] The Provider's motion for reinstatement has failed to dissuade the Board from altering its November 20, 2019 determination. Rather, the Board finds that its analysis in that determination remains

[6] (Emphasis added.)
[7] (Emphasis added.)
[8] (Emphasis added.)
[9] *See* Board Rules 25, 27; 42 C.F.R. § 405.1868(a)-(b). *See also* Board Rule 25.3 (providing an overview of position paper filing requirements with cross-references).

appropriate and that the Provider has failed to establish the requisite "good cause" under Board Rule 47.3 to justify reinstatement.

In support of its motion for reinstatement, the Provider tries to conflate whether it had "good cause" to request abeyance with whether it had "good cause" for failing to file an FPP in compliance with the Board's filing requirements. The hollowness of this claim (as well as the perfunctory nature of the FPP) is highlighted by both the FPP's silence on *Pomona Valley* and the silence of the request for abeyance on the Provider's then-upcoming FPP filing.[10] In its motion for reinstatement, the Provider focuses on the import of the *Pomona Valley* case as a controlling authority and how it is similar to the Provider's appeal and how an abeyance was appropriate. However, notwithstanding the alleged significance and import of this case, the Provider failed to even cite to or discuss *Pomona Valley* in its FPP (much less reference its request for abeyance in the FPP).[11]

Moreover, it is clear that the Provider needed to brief *Pomona Valley* in its FPP because the extent to which *Pomona Valley* could be relevant is not clear. *Pomona Valley* focuses on the fact that, under the California Medicaid program, individuals who receive SSI benefits are automatically eligible for the California Medicaid program and asserts that California Medicaid program records can be used as a substitute for SSI data and leads to more accurate SSI fractions.[12] The Provider's only explanation for not including evidence related to the Florida Medicaid program is that it preferred to defer incurring costs associated with obtaining and analyzing SSI data from the Florida Medicaid program until the *Pomona Valley* litigation is resolved because it will allegedly establish whether that Florida Medicaid evidence is sufficient to show that the SSI percentage used by the Medicare Contractor is understated.[13] However, in an attempt to avoid incurring costs, the Provider appears to oversimplify its case as it is not clear that the facts in the *Pomona Valley* are essentially the same as the ones in this case. The Medicaid program is a joint federal and state program that varies from state to state. In this

[10] If the Provider needed more time *to meet the position paper requirements*, the Provider could have requested a "good cause" extension. In this regard, the Board notes that Board Rule 23.5 permits parties to request extension on position paper filing deadlines: "Requests for extensions for filing a PJSO or preliminary position paper must be filed at least three weeks before the due date and will be granted *only for* ***good cause***." (Emphasis added.) However, the Provider did not request such a "good cause" extension of the FPP and instead made an insufficient FPP filing. As previously noted, the request for abeyance did not discuss the then-upcoming FPP deadline and a pending request for abeyance alone is not "good cause" to be considered a request an extension on an FPP as noted by Board Rule 23.6.

[11] Indeed, the absence of any discussion of *Pomona Valley* in the FPP suggests the Provider abandoned the legal theories associated with *Pomona Valley* that the Provider discusses in both its request for abeyance and its motion for reinstatement but not in its FPP. The absence of the discussion of *Pomona Valley* is that much more conspicuous when one reviews the Provider's treatment of the Dual Eligible Days issue (another issue that was transferred and as such is no longer pending in this case) in its request for abeyance and its FPP. In connection with Dual Eligible Days issue, the request for abeyance at 2 discusses the significance of a particular appeal pending before the Ninth Circuit (*Empire Health Found. for Valley Hosp. v. Med. Ctr. v. Price*) and, similarly, the FPP section on the Dual Eligible Days issue at 6-8 does include significant discussion and references related to that pending appeal.

[12] *See Pomona Valley Hosp. Med. Ctr. v. Noridian Healthcare Solutions*, PRRB Dec. No. 2018-D50 (Sept. 21, 2018) (hereinafter "*Pomona Valley* PRRB Dec. No. 2018-D50").

[13] Provider's Motion of Reinstatement at 2.

regard, 42 C.F.R. § 430.0 states: "Within ***broad*** Federal rules, *each* State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures."[14] Notwithstanding this variation, the FPP fails to discuss the Florida Medicaid program or the relevance of Florida Medicaid data to the alleged systematic errors in the SSI matching process. Moreover, apart from unsupported assertions in the request for abeyance and the motion for reinstatement, the record is devoid of any discussion or evidence on the Florida Medicaid program, including potential parallels between Medicaid eligibility under the California Medicaid program and Medicaid eligibility under the Florida Medicaid program (*e.g.*, information on the eligibility process including eligibility standards, administration, and record keeping).[15]

In the same vein, the Board notes that the FPP did not include any evidence to establish the material facts in this case relating to the SSI fraction at issue.[16] The only evidence the Provider references in its FPP for the sole issue remaining in this case concerns its "DSH Data File" which is presumably MedPAR data and that reference occurs only in one sentence in footnote 1 of the FPP. Specifically, the Provider alleges that it "requested its DSH Data File from CMS in order to review the data used to calculate its SSI ratio." However, notwithstanding Board Rule 25.2.2, the FPP does not provide any information or documents relating to the status of that request nor does it allege any improper handling of that request on the Agency's part (*e.g.*, alleging improper withholding of information or alleging violation of a regulation or statute). Indeed, the Medicare Contractor asserts that "[a]ccording to CMS, the Provider requested and received MedPAR data for analysis back in December 2012" and that "[i]t is unclear why the Provider has been unable to verify the data."[17] If the Medicare Contractor's allegation is true, the Board would have expected the Provider's FPP to include some discussion of its analysis of the data and the relevance of the data to the alleged systematic errors in the SSI matching process.

Finally, the motion for reinstatement makes a new argument not discussed in the FPP relating to access to SSI data. Specifically, the motion alleges that "the government has categorically refused to make [SSI data maintained by the Social Security Administration] available to providers" and therein footnotes to the *Pomona Valley* case as its sole support for this allegation. Accordingly, this allegation appears to be based solely on *Pomona Valley* and again is a new argument that is not discussed in the Provider's FPP.

---

[14] (Emphasis added.)
[15] *See Pomona Valley* PRRB Dec. No. 2018-D50 (discussing the details of the coding, record keeping and other administration of eligibility under the California Medicaid program).
[16] The FPP includes only two exhibits: (1) a copy of *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008); and (2) a copy of Provider Reimbursement Manual, CMS-Pub. 15-2, § 3630.1.
[17] Medicare Contractor FPP at 7. The Board further notes that there appears to be an established process to obtain this information. *See*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH (CMS webpage describing access to DSH data ***from 1998 to 2017***: "DSH is now a self-service application. This new self-service process enables you to enter your data request(s) and retrieve your data files through the CMS Portal.").

In summary, as discussed in the Board's November 20, 2019 determination, the potential applicability of *Pomona Valley* to the Provider's case before the Board did not eliminate or obviate the Provider's responsibility to fully develop in the FPP its argument and the merits of its case (including material facts and evidence), particularly since this appeal has been pending for over six years. The Board reiterates that it is the Provider's responsibility to develop its case based on the established deadlines in accordance with Board Rules. The Provider failed to do so and has not established "good cause" under Board Rule 47.3 to justify reinstatement. Rather, the deficient filing appears to be the result of administrative oversight and/or a desire not incur costs. Therefore, the Board denies the Provider's motion to reinstate Case No. 13-2953.

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:

4/9/2020

X Clayton J. Nix

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

cc: Mark Polston, King & Spalding, LLP
Geoff Pike, First Coast Service Options
Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Joanne Erde, Esq.
Duane Morris
200 South Biscayne Blvd., Ste. 3400
Miami, FL 33131

Geoff Pike, Appeals Coordinator
First Coast Service Options, Inc.
Provider Audit & Reimbursement Dept.
532 Riverside Ave.
Jacksonville, FL 32202

RE: ***Jurisdictional Determination***
Memorial Regional Hospital (Prov. No. 10-0038)
FYE 4/30/2009
Case No. 14-0869

Dear Ms. Erde and Mr. Pike,

This case involves the Provider's appeal of its Medicare reimbursement for the fiscal year ending ("FYE") April 30, 2009. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation is response to the Medicare Contractor's Jurisdictional Challenge, the Provider's Jurisdictional Response, and the June 8, 2018 decision of the U.S. Court of Appeals, District of Columbia Circuit ("D.C. Circuit") in *Mercy Hosp., Inc. v. Azar* ("*Mercy*"), on June 8, 2018.[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the related issues within the instant appeal.

Pertinent Facts

On November 19, 2013, the Provider submitted an appeal request and the Board assigned to Case No. 14-0869. The appeal request only included one issue: "The Provider is appealing the Intermediary's exclusion of days associated with a Section 1115 Medicare waiver program known as the Florida Low-Income Pool from the numerator of the Medicaid fraction of the disproportionate share hospital ("DSH") adjustment."

Shortly thereafter, on November 26, 2013, the Provider filed a second appeal request which was incorporated into the same appeal, Case No. 14-0869. The second appeal request contained the following three issues relating to the inpatient prospective payment system ("PPS") for inpatient rehabilitation facilities ("IRFs"). Specifically, these three IRF-PPS issues relate to an adjustment within that payment system for low income payments ("LIP"): (1) Whether the MAC used the correct Supplemental Security Income ("SSI") percentage in the LIP calculation; (2) Whether the Medicaid dual eligible days should be included in the Medicaid fraction or Medicare fraction of

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).

the LIP calculation; and (3) Whether the Medicaid Part C days should be included in the Medicaid fraction or Medicare fraction of the LIP calculation.

The Provider transferred the Section 1115 waiver day issue to Case No. 14-2151G. As a result, the three remaining issues in this appeal relate to the LIP adjustment for IRF PPS. On January 7, 2020, the Medicare Contractor filed a jurisdictional challenge for these remaining three issues. The Provider submitted its response on February 6, 2020.

Medicare Contractor's Position

The Medicare Contractor contends that the IRF-PPS LIP adjustment is a component of the IRF prospective payment rate established under 42 U.S.C. § 1395ww(j)(3)(A)(v). In accordance with § 1395ww(j)(8)(B), there is no administrative or judicial review of the IRF prospective payment rates under paragraph (3). Because the IRF LIP payment has been established under paragraph (3), the Medicare Contractor contends that the Board does not have subject matter jurisdiction over the IRF LIP payment or any of its components.

42 U.S.C. § 1395ww(j)(8)(B) specifically prohibits and precludes administrative and judicial review of prospective payment rates established under § 1395ww(j)(3). One of these adjustments to the rate is the LIP adjustment.

The Medicare Contractor cites to the D.C. District Court in *Mercy* where the court upheld the Administrator's decision holding that "the plain language of the statute precludes review of the contractor's determination."[2] The Medicare Contractor explains that, on June 8, 2018, the U.S. Appellate Court for the D.C. Circuit ("D.C. Circuit") affirmed the District Court's *Mercy* decision.[3]

Provider's Position

The Provider contends that the Board has jurisdiction over the IRF-PPS LIP adjustment issues for the following reasons.

The Provider argues that it meets the statutory requirements for a Board hearing under § 1395oo(a) and that the IRF-PPS statute does not preclude review of the IRF-PPS LIP adjustment. 42 U.S.C. § 1395ww(j)(8) contains the following provision limiting administrative and judicial review:

> (8) LIMITATION ON REVIEW. There shall be no administrative or judicial review under section 1395ff of this title, 1395oo of this title, or otherwise for the establishment of –
> (A) case mix groups, of the methodology for the classification of

[2] Medicare Contractor's Jurisdictional Challenge at 4.
[3] *Id*. at C-6.

> patients within such groups, and of the appropriate weighting factors thereof under paragraph (2);
> (B) the prospective payment rates under paragraph (3);
> (C) outlier and special payments under paragraph (4); and
> (D) area wage adjustments under paragraph (6).

The Provider argues that, significantly, the IRF-PPS statute precludes review of the establishment of "the *prospective payment rates* under paragraph (3)" of Section 1395ww(j).[4] Thus, the Provider concludes, the statute precludes judicial and administrative review only of the weights and other inputs that determine unadjusted IRF-PPS rates and not facility-specific adjustments adopted by the Secretary through his authority to adjust payment rates as "necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities."[5]

The Provider also argues that, until the recent issuance of D.C. Circuit's decision in *Mercy*, the Board consistently interpreted the statutory language in § 1395ww(j)(8)(B) as precluding review only of the *unadjusted* prospective payment rates under paragraph (3) of § 1395ww(j) and not the facility-specific adjustments adopted by the Secretary to those rates. Accordingly, the Board repeatedly rejected jurisdictional challenges based on § 1395ww(j)(8) to appeals of the Medicare contractors' calculation of the IRF-PPS LIP adjustment payment.[6]

The Provider asserts that the D.C. Circuit's decision in *Mercy* is not dispositive regarding the Board's jurisdiction in this appeal. The D.C. Circuit's decision is not binding on District Courts or Courts of Appeals in other federal judicial circuits. The Provider is located in Florida, which is within the geographic jurisdiction of the Court of Appeals for the Eleventh Circuit. Under 42 U.S.C. § 1395oo(f), the Provider may appeal adverse decisions of the Board or the CMS Administrator to the appropriate district court within the Eleventh Circuit, which has not yet addressed the jurisdiction issue relating to the IRF-PPS LIP adjustment.

Finally, the Provider argues that "[w]hile CMS has attempted to "clarify" its position that the statute and implementing regulation bar jurisdiction of this issue, *see* 78 Fed. Reg. 47860, 47900 (Aug. 6, 2013); *see also Mercy Hospital v. First Coast Service Options, Inc.*, CMS Adm'r Dec. (June 1, 2015), the plain language of the statute controls. Moreover, in its subsequent attempts to clarify its position, CMS's failure to acknowledge its original, more limited view of the statutory preclusion of review denied interested parties clear notice of, and a meaningful opportunity to comment on, the change in the agency's position. Thus, the agency failed to comply with notice and comment rulemaking requirements of the Administrative Procedure Act and the Medicare statute."[7]

---

[4] 42 U.S.C. § 1395ww(j)(8)(B) (emphasis added).
[5] 42 U.S.C. § 1395ww(j)(3)(A)(v).
[6] Provider's Response to MAC's Jurisdictional Challenge at 10-13.
[7] *Id*. at 17-18.

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates under the IRF-PPS. Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy* answers this question and clarifies what is shielded from review in its analysis of this issue.[8]

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the District Court's decision, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[9] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[10]

---

[8] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).
[9] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).
[10] *Mercy*, 891 F.3d at 1068.

In the instant appeal, the Provider seeks Board review of several of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI percentage, dual eligible days, and Part C days. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board finds that it lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the three (3) remaining issues in the instant appeal that challenges this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent because the Provider could bring suit in the D.C. Circuit.[11]

As there are no issues remaining in the appeal, the Board hereby closes Case No. 14-0869. Review of this decision is available under 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
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

4/10/2020

X Clayton J. Nix

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Daniel J. Hettich, Esq.
King & Spalding, LLP
1700 Pennsylvania Ave., NW
Washington, DC 20006-4706

RE: *EJR Determination*

20-1159GC	Trinity Health FFY 2020 Section 401 Hospitals Rural Floor Group
20-1161GC	Cleveland Clinic FFY 2020 Section 401 Hospitals Rural Floor Group
20-1163GC	UF Health Central Florida FFY 2020 Section 401 Hospitals Rural Floor Group
20-1164GC	HonorHealth FFY 2020 Section 401 Hospitals Rural Floor Group
20-1168G	King & Spalding FFY 2020 Section 401 Hospitals Rural Floor Group
20-1170GC	BayCare Health FFY 2020 Section 401 Hospitals Rural Floor Group

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 18, 2020 request for expedited judicial review ("EJR") for the above-referenced six (6) group appeals. 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 IV.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

---

[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).

state.[11] To correct this problem, in § 4410(a) of the Balanced Budget Act of 1997 ("BBA"), 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.

---

[11] H.R. Rep. No. 105-149, at 1305 (1997).
[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)).

> (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 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."

[17] *Id.* (emphasis added).
[18] H.R. Conf. Rep. No. 106-479, 512 (1999).
[19] 65 Fed. Reg. 47026, 47031, 47048 (Aug. 1, 2000).

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 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]

---

[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.
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.* at 20377.

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 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 two policies:

1. The policy "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)";[31] and

2. The policy, "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

---

[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).
[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.

> rural under [42 U.S.C. § 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 [42 U.S.C. § 1395ww](d)(8)(C)(iii)]."[32]

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

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

In the FFY 2020 IPPS proposed rule,[33] 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.[34] 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.[35]

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.[36]

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.[37]

---

[32] *Id.*
[33] 84 Fed Reg. 19158, 19396-8 (May 3, 2019).
[34] 84 Fed. Reg. at 42333, 42336.
[35] *Id.* at 42333.
[36] *Id*.
[37] *Id.* at 42334.

> 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 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.[38]

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.[39]

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).[40] 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)."[41] 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

[38] *Id.*
[39] *Id.*
[40] BBA § 4410(a) (available at 42 U.S.C. § 1395oo note).
[41] 84 Fed. Reg. at 42336.

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,"[42] and BBA § 4410(a) specifies that the wage index for hospitals in a state "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." 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 of rule 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 six (6) group appeals within this EJR request have filed an appeal involving FFY 2020 based on their appeals 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.[43] The Board has determined the participants' documentation for each of the groups shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[44] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned six (6) group appeals and the underlying Providers. The estimated amount in

[42] 42 U.S.C. § 1395ww(d)(8)(E)(1).
[43] 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).
[44] *See* 42 C.F.R. § 405.1837.

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 relevant *cost reporting periods* for the participants in these group appeals 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 related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports.[45] However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether any of the relevant participants' cost reports 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 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.[46]

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.[47] Specifically, in the preamble to FFY 2020 IPPS final rule, the Secretary announced the following two policies to address wage index disparities:

1. The policy "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)";[48] and

2. The policy, "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 [42 U.S.C. § 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 [42 U.S.C. § 1395ww](d)(8)(C)(iii)]."[49]

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,

---

[45] *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015).
[46] *See* 80 Fed. Reg. at 70556, 70569-70.
[47] *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").
[48] 84 Fed Reg. at 42336.
[49] *Id.*

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 index for rural areas in the State in which the county is located'' referred to in section [1395ww](d)(8)(C)(iii) . . . .[50]

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."[51]

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.

D. Board's Decision Regarding the EJR Request

The Board finds that:

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

---

[50] *Id.*

[51] 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 . . . ."

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 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 H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

4/15/2020

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Pam VanArsdale, National Government Services
Geoff Pike, First Coast Services Options
John Bloom, Noridian Healthcare Solutions
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Lisa Ellis
Toyon Associates, Inc.
1800 Sutter Street, Ste. 600
Concord, CA 94520

Lorraine Frewert
Noridian Healthcare Solutions c/o
Cahaba Safeguard Administrators
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Jurisdictional Decision and Request for Transfer of Issues***
San Francisco General Hospital (05-0228)
FYE 6/30/2008
Case No. 19-2550

Dear Ms. Ellis and Ms. Frewert:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced individual appeal in response to the Representative's recent request to transfer the issues to group appeals. The pertinent facts and the jurisdictional decision of the Board is set forth below.

Pertinent Facts:

In a reopening request filed with the Medicare Contractor on September 18, 2017, the Provider requested ". . . a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year."[1] The Medicare Contractor's Notice of Reopening was issued on October 18, 2017 and confirmed that the cost report was being reopened to adjust the SSI ratio based on the hospital's cost reporting period rather than the federal fiscal year.

On March 12, 2019, the Provider was issued a revised Notice of Program Reimbursement ("NPR") for fiscal year end ("FYE") 06/30/2008.

On August 28, 2019, the Provider's Representative, Toyon Associates, Inc. ("Toyon") filed an individual appeal for the Provider from receipt of the revised NPR which included two issues: Accuracy of CMS Developed SSI Ratio and DSH Inclusion of Medicare Part C Days in the SSI Ratio. The Board acknowledged the individual case, assigning it to Case No. 19-2550 and setting the Provider's preliminary position paper due date for April 24, 2020.

In correspondence filed on March 25, 2020, Toyon requested the transfer of the two issues from the individual appeal to two fully formed optional groups pending for these issues:

[1] Toyon Cost Report Reopening & SSI Realignment Request at 1 (Sept. 18, 2017).

1. Case No. 18-0532G, Toyon 2008 Accuracy of CMS Developed SSI Ratio Group III; and
2. Case No. 18-0533G, Toyon 2008 Inclusion of Medicare Part C Days in the SSI Ratio Group.

Both groups were filed on January 22, 2018 and were closed to the addition of participants on March 1, 2019.

In its transfer requests, Toyon indicates that the subject Provider is already a participant in both groups based on its appeal of its original NPR and, therefore, asks that the Board allow the transfer of the issues from this *revised* NPR appeal. In addition, Toyon certifies that there are no other open groups pending and no other providers appealing these issues for 2008.

Board's Decision:

The Board finds that it does not have jurisdiction over the Accuracy of CMS Developed SSI Ratio and the DSH Inclusion of Medicare Part C Days in the SSI Ratio issues for San Francisco General Hospital that were appealed from the March 12, 2019 *revised* NPR. The Board finds that the Provider's revised NPR did not adjust either issue. Adjustment Nos. 4 and 6 on the Provider's audit adjustment report related to the revised NPR were to revise the SSI percentage and DSH percentage based on the latest CMS letter of SSI percentage realignment which were based on the Provider's request to CMS. This realigned SSI percentage only adjusted the total number of SSI days from being calculated based on the federal fiscal year to being calculated based on the cost reporting fiscal year. Neither the flaws and inaccuracies of the CMS matching process, nor the question regarding the inclusion of Part C days in the SSI fraction were part of the cost report revision.

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

The Provider requested that its SSI percentages be recalculated from the federal fiscal year to cost reporting year. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used.[2] The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the September 30 Federal fiscal year.[3]

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

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

The regulation, 42 C.F.R. § 405.1889 (2012), describes the limited rights that providers have to appeal *revised* determinations:

> (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 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.
>
> (b)(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.

These regulations make clear that a Provider can only appeal items that are specifically adjusted from a revised NPR. The Provider has appealed the Accuracy of CMS Developed SSI Ratio and the DSH Inclusion of Medicare Part C Days in the SSI Ratio issues, which were not adjusted in the revised NPR.

Additionally, the Board notes that the Provider is not harmed by this dismissal since it already has previously appealed these issues from its original NPR *for the same FYE* and subsequently transferred the issues to the subject group cases (Case Nos. 18-0532 and 18-0533G).

The Board finds that it does not have jurisdiction over the Accuracy of CMS Developed SSI Ratio and the DSH Inclusion of Medicare Part C Days in the SSI Ratio issues appealed from the *revised* NPR issued for San Francisco General Hospital for FYE 06/30/2008 because the issues were not specifically adjusted in the revised NPR. Accordingly, the Board ***dismisses*** *these two issues* from Case No. 19-2250 and ***denies*** *the transfer* of these two issues from Case No. 19-2550 to Case Nos. Case Nos. 18-0532 and 18-0533G. As there are no other issues pending in the *revised* NPR appeal for San Francisco General Hospital, the Board hereby closes Case No. 19-2550 and removes it from the Board's docket.

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

4/15/2020

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dylan Chinea, Toyon Associates, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Robert L. Roth, Esq.
Hooper, Lundy and Bookman
401 9th Street, NW, Ste. 550
Washington, D.C. 20004

RE: **Expedited Judicial Review Determination**
20-0832GC Care New England FFY 2020 Area Wage Index Standardized Amt. Reduction Grp
20-0834GC Emory Healthcare FFY 2020 Area Wage Index Standardized Amt. Reduction Grp
20-0835GC UNC Health FFY 2020 Area Wage Index Standardized Amount Reduction Grp
20-0836GC Univ. of Chicago FFY 2020 Area Wage Index Standardized Amt. Reduction Grp
20-0837GC Yale FFY 2020 Area Wage Index Standardized Amount Reduction Grp
20-0839GC Hooper, Lundy & Bookman FFY 2020 Area Wage Index Standardized Amt. Reduction Grp

Dear Mr. Roth:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 20, 2020 requests for expedited judicial review ("EJR") in the above referenced appeals.[1] The decision of the Board is set forth below.

The issue for which EJR has been requested is:

> [W]hether the Hospitals' FFY 2020 standardized amount and hospital-specific operating IPPS [inpatient prospective payment system] payment rate[s] were improperly reduced by approximately 0.2016% for FFY 2020.[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

[1] The Board recognizes that this EJR request was submitted subsequent to the Board's temporary change in operations due to the COVID-19 developments as discussed more fully in Board Alert 19. Notwithstanding, the Board was still able to process this EJR request for these group appeals within 30 calendar days of the EJR filing as it only involves appeals of a Federal Register Notice and there are no challenges under 42 C.F.R. §45.1873.
[2] Providers' EJR requests at 1.
[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

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"). 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[6] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget.[7] The wage index also reflects certain geographic reclassifications of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[8]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals.[9] Data included in the wage index is derived from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary determines an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation).[10] A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[11]

Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule, the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage

[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) 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] of the Department of Health and Human Services.
[7] 84 Fed. Reg. 42044, 42300 (Aug. 16, 2019).
[8] *See* https://cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/wage.
[9] 84 Fed.Reg. at 42300.
[10] *Id.* at 42305.
[11] *Id.*

index.[12] The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[13] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of States to manipulate the wage index system to 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."[14] Based on these concerns, the Secretary proposed "[t]o help mitigate the wage index disparities" by "reduc[ing] the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . ."[15]

In the FY 2020 IPPS final rule, the Secretary summarizes its proposal as follows:

> [N]otwithstanding the challenges associated with comprehensive wage index reform, we agree with respondents to the request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. (We noted that this lag results from the fact that the wage index calculations rely on historical data.) We also agreed that addressing this systemic issue did not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure." Therefore, in response to these concerns, in the FFY 2020 LTCH PPS proposed rule . . . , we proposed a policy that would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index.[16]

In the FFY 2020 IPPS final rule, the Secretary finalized the "proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th

[12] 83 Fed. Reg. 20164, 20372-77 (May 7, 2018).
[13] 84 Fed Reg 19158, 19393-94 (May 3, 2019)).
[14] *Id.*
[15] *Id.*
[16] 84 Fed. Reg. at 42326 (citations omitted).

percentile wage index value across all hospitals is 0.8457."[17] In doing so, the Secretary determined that "quartiles are a reasonable method of dividing the distribution of hospitals' wage index values" and that "identifying hospitals in the lowest quartile as low wage index hospitals, hospitals in the second and third 'middle' quartiles as hospitals with wages index values that are neither low nor high, and hospitals in the highest quartile as hospitals with high wage index values, is a reasonable method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[18]

The Secretary acknowledged that "there is no set standard for identifying hospitals as having low or high wage index values"; however, he believes his "proposed quartile approach is reasonable for this purpose, given that . . . quartiles are a common way to divide distributions, and that our approach is consistent with approaches used in other areas of the Medicare program." The Secretary stated in the proposed rule that, based on the data for the proposed rule, for FY 2020, the 25th percentile wage index value across all hospitals was 0.8482 and that this number would be updated in the final rule based on the final wage index values.[19] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[20]

Under the Secretary's methodology, he decided to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage indices for these hospitals would be equal to half of the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year for all hospitals.[21] The Secretary announced that this policy would be in effect for at least 4 years beginning in FFY 2020, in order to allow employee compensation increases implemented by low wage index value hospitals sufficient time to be reflected in the wage index calculation. The Secretary explained that, for the FFY 2020 wage index, data from 2016 cost reports was used to calculate the wage indices and 4 years is the minimum time before increases in employee compensation included in Medicare cost reports could be reflected in the wage index. The Secretary acknowledged that additional time may be necessary to determine the duration of the policy.[22]

Budget Neutrality and the Wage Index

In the 2020 Proposed IPPS Rule, the Secretary explained that he believed that, while it would not be appropriate to create a wage index floor or a wage index ceiling, it would be appropriate to provide a mechanism to increase the wage index of low wage index hospitals while maintaining budget neutrality for that increase through an adjustment to the wage index of high wage index hospitals. The Secretary maintains that this action has two key merits: (1) "by compressing the

[17] *Id.* at 42328.
[18] *Id.* at 42326.
[19] *Id.*
[20] *Id*
[21] *Id.*
[22] *Id.* at 42326-7.

wage index for hospitals on the high and low ends, that is, those hospitals with a low wage index and those hospitals with a high wage index, such a methodology increases the impact on existing wage index disparities more than by simply addressing one end;" and (2) "such a methodology ensures those hospitals in the middle, that is, those hospitals whose wage indices are not considered high or low, do not have their wage index values affected by this proposed policy."[23] Thus, the Secretary concludes that, "given the growing disparities between low wage index hospitals and high wage index hospitals, . . . it would be appropriate to maintain budget neutrality for the low wage index policy proposed . . .by adjusting the wage index for high wage index hospitals."[24]

Following significant criticism from commenters to the proposed rule, the Secretary acknowledged that "some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between the proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States."[25] Based on this feedback, the Secretary decided to "finalize a budget neutrality adjustment for our low wage hospital policy but . . . not [to] finaliz[e] our proposal to target that budget neutrality adjustment on high wage hospitals" given that: (1) budget neutrality is required under [§ 1395ww(d)(3)(E)]; (2) even if it were not required, he believes that it would be inappropriate to use the wage index to increase or decrease overall IPPS spending; and (3) he wished to consider further the policy arguments raised by commenters regarding the budget neutrality proposal.[26] Specifically, "consistent with the Secretary's current methodology for implementing wage index budget neutrality under [§ 1395ww(d)(3)(E)] and the alternative approach we considered in the proposed rule (84 FR 19672), we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in the rule, is implemented in a budget neutral manner."[27]

Providers' Position

The Providers are challenging their IPPS payments for 2020 on the grounds that those payments were and continue to be improperly *understated* as a result of the reduction to the standardized amount, which the Secretary allegedly unlawfully imposed as part of the new policy increasing the wage index values of hospitals with an average wage index ("AWI") in the lowest quartile. The Providers explain that, in the FFY 2020 IPPS final rule, the Secretary sought to address what he called "wage index disparities" by adopting a number of new policies that impacted the AWI values and IPPS reimbursement hospitals receive. One of the policies increases the AWI values of hospitals with an AWI in the lowest quartile nationally ("AWI subsidy"). The Providers contend that the AWI subsidy increased the AWI values of hospitals with AWI values in the lowest quartile by half of the difference between their accurately calculated AWI and the 25th

[23] *Id*. at 42329.
[24] *Id.* at 42328-9.
[25] *Id.* at 42331.
[26] *Id*.
[27] *Id*.

percentile of AWI values. Further, the Providers note that, while the Secretary asserted that he had the authority to implement this new policy under 42 U.S.C. § 1395ww(d)(3)(E), this section of the statute only authorizes the Secretary to adjust the labor-related portion of hospital payments to account "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level."

Further, the Providers allege issues with the Secretary's election to implement the new AWI Subsidy in a budget neutral manner. Specifically, the Providers allege, the Secretary decreased the standardized payment amounts of all IPPS hospitals by 0.2016 percent to offset the AWI increases to those hospitals in the lowest AWI quartile. The Providers point out that the Secretary asserts that he had the authority to implement this budget neutrality adjustment under 42 U.S.C. § 1395ww(d)(3)(E) and that, even if he did not have such authority under § 1395ww(d)(3)(E), he would invoke his statutory "exceptions and adjustments" authority in support of such a budget neutrality adjustment. This "exceptions and adjustments" authority provision, codified at 42 U.S.C. § 1395ww(d)(5)(I), addresses IPPS payments and states: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate."

The Providers argue that the Secretary lacks the authority, under his "exceptions and adjustment" authority under 42 U.S.C. § 1395ww(d)(3)(E), or otherwise in order to establish the AWI subsidy in the manner set forth in the FFY 2020 Final IPPS Rule. Similarly, the Provider argue that, even if he had lawfully established such a subsidy, he cannot lawfully reduce the standardized amount in the manner that he did as part of his implementation of the AWI Subsidy. Consequently, the Providers are challenging the reduction of the standardized amount on several grounds, including, but not limited to, that: (1) it exceeds statutory authority; (2) it contradicts the AWI congressional mandated; (3) it was developed in an arbitrary and capricious manner; (4) it lacks support from substantial evidence; and (5) it is otherwise defective both procedurally and substantively. The Providers further contend that there is no statute that precludes administrative or judicial review of the Secretary's adjustments for different area wage levels under 42 U.S.C. § 1395ww(d)(3)(E) or adjustments under 42 U.S.C. § 1395ww(d)(5)(I).

Accordingly, the Providers maintain that EJR is appropriate because the Board has jurisdiction over the appeals, the Providers are dissatisfied with the final determination of the Secretary, and the Board lacks the authority to decide the question at issue and cannot grant the relief sought. Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all the provisions of Title XVIII of the Social Security Act and is therefore, bound to apply the 0.2016 percent reduction issued by the Secretary in the FFY 2020 IPPS final rule.

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.[28] The Board has determined that: (1) the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[29] and (2) the appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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

The Board notes that the relevant *cost reporting period(s)* of the participants in these group appeals 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.[30] However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether the relevant participants' cost reports 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 appealing the FFY 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.[31]

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to finalized a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals was implemented in a budget neutral manner was made through notice and comment in the form of an uncodified regulation.[32] Specifically, in the preamble to FFY 2020 IPPS Final Rule, the Secretary announced the following wage index issues:

1. "To help mitigate . . . wage index disparities [between high and low wage index hospitals], including those resulting from the inclusion of hospitals

---

[28] 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), CCH Medicare & Medicaid Guide ¶ 41,025, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015) [30] *See* 42 C.F.R. § 405.1837.

[29] *See* 42 C.F.R. § 405.1837.

[30] *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015).

[31] *See* 80 Fed. Reg. at 70556, 70569-70.

[32] *See* 84 Fed. Reg. 42044, 42325-36 "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.

> with rural reclassifications under 42 CFR 412.103 in the calculation of the rural floor, . . . we . . . reduce the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . .";[33] and

2. "[A]ddressing this systemic issue does not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."[34]

The Secretary did not incorporate into the Code of Federal Regulations the new policy setting forth a modification to the wage index calculation determination by finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that there was an increase in the wage index for low wage index hospitals. 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:

> We acknowledge, however, that some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between our proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States. Therefore, given that budget neutrality is required under section 1886(d)(3)(E) of the Act, given that even if it were not required, we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending, and given that we wish to consider further the policy arguments raised by commenters regarding our budget neutrality proposal, we are finalizing a budget neutrality adjustment for our low wage hospital policy, but we are not finalizing our proposal to target that budget neutrality adjustment on high wage hospitals. Instead, consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act and the alternative approach we considered in the proposed rule . . ., we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index

[33] *Id.* at 42326.
[34] *Id.*

> hospitals, as finalized in this rule, is implemented in a budget neutral manner.[35]

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 Wage Index." 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."[36]

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 Wage Index 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 Wage Index which they allege improperly reduces the standardized amount. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the participants in these 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 Wage Index published in the IPPS 2020 final rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Wage Index 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 issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the

---

[35] *Id.* at 42331.
[36] 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 . . . ."

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:

4/17/2020

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Pam VanArsdale, NGS
Cecile Huggins, Palmetto GBA
Laurie Polson, Palmetto GBA c/o NGS
Danene Hartley, NGC
Byron Lamprecht, WPS
Wilson Leong, FSS