**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
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**Via Electronic Delivery**

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RE: ***Jurisdictional Determination***
Pioneers Memorial Healthcare District (05-0342), FYE 06/30/2013
PRRB Case No. 19-0700

Dear Mr. Bunting and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

## Background

The Provider's Request for Reopening was filed on February 23, 2018 in which the Provider indicated that

> . . . the SSI ratio published for federal fiscal year 2012 (i.e. 10/1/2011 – 9/30/2012), which is utilized by the MAC in the Provider's 6/30/2013 DSH entitlement calculations, fails to accurately represent the SSI ratio applicable to the Provider's cost reporting year (i.e. 7/1/2012 – 6/30/013). Specifically, the published FFY 2012 SSI ratio includes three months of common patient data between these two fiscal years (July 1st to September 30th overlap) in lieu of twelve full months of common patient data.[1]

The Notice of Reopening was issued on April 4, 2018, in which the MAC advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's Disproportionate Share Adjustment based on data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the Disproportionate Share Adjustment to account for the change in the SSI ratio."

[1] *The Provider's reopening request also included language requesting that the Medicare Part C days be excluded from the SSI ratio realignment process based on the federal appellate court decision in Allina Health Services.*

The Notice of Amount of Corrected Reimbursement (RNPR) was issued on November 28, 2018.[2]

The individual appeal for the Provider was filed by Moss Adams, LLP on January 18, 2019, to which the Board assigned Case No. 19-0700. The sole issue in the appeal is "Medicare DSH Payments - CMS Inclusion of Medicare Managed Care Part C Days in the Realigned SSI Ratio Determined by CMS on or about November 28, 2018." ("Managed Care Part C days")

The Provider referenced audit adjustment #4 for the issue. Adjustment #4 was issued "[t]o include the SSI % and the Disproportionate Share Amount based on the latest CMS letter of SSI% Realignment."

**Board Determination**

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

**Relevant Regulations – RNPRs**

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

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

Additionally, 42 C.F.R. § 405.1889 (2018)[3] explains the effect of a cost report revision:

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

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

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

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

The Board finds that it does not have jurisdiction over the sole issue in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request, and did not specifically adjust the DSH Managed Care Part C days issue. As a result, the Provider does not have the right to appeal this issue under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The adjustment and reopening in this case were issued as a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Reopening Request and Adjustment #4, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. The Board has consistently found that it does not have jurisdiction over the DSH Managed Care Part C Days issue when it is appealed from a revised NPR issued as a result of a provider's request for realignment of its SSI percentage. As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

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

[4] 42 C.F.R. § 405.1889(b)(1).

> (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 data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[6] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[7]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*. . . .

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal*

[5] (Emphasis added.)
[6] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[7] (Emphasis added.)

> *fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[8]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days or Part A days) because that data had been previously gathered on a month-by-month basis and there is no need for CMS to rerun the data matching process in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

In other words, the relevant NPR was only being reopened to include the realigned SSI percentage. Since the only matter specifically revised in the RNPR was to realign the SSI percentage from federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the DSH Managed Care Part C days issue in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[9]

In conclusion, the Board ***dismisses*** the DSH Managed Care Part C days issue appealed from the RNPR in Case No. 19-0700 as the Provider does not have the right to appeal the RNPR at issue for this issue. As there are no other issues in the individual appeal, the Board hereby closes Case No. 19-0700 and removes it from the Board's docket.

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

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

FOR THE BOARD:

5/12/2021

X Clayton J. Nix

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

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

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

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**Via Electronic Delivery**

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Denver, CO 80202

**RE:** ***EJR Determination***

18-1245GC SPB 2006 Hackensack Meridian Health Medicare Outliers Group
14-3706GC JFK Health System 2006 Outlier Threshold Group
15-0418GC JFK Health System 2007 Outlier Threshold Group
15-1835GC JFK Health System 2008 Outlier Threshold Group
16-0128GC Meridian Health 2011 Outlier Threshold Group
16-0129GC Meridian Health 2010 Outlier Threshold Group
18-1244GC SPB 2007 Hackensack Meridian Health Medicare Outliers Group
18-1246GC SPB 2008 Hackensack Meridian Health Medicare Outliers Group
18-1247GC SPB 2009 Hackensack Meridian Health Medicare Outliers Group
18-1248GC SPB 2012 Hackensack Meridian Health Medicare Outliers Group
18-1249GC SPB 2013 Hackensack Meridian Health Medicare Outliers Group

Dear Mr. Collins:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' September 22, 2020 and October 9, 2020[1] requests for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Effect of COVID -19 on Board Operations:**

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties "Temporary COVID-19 Adjustments to PRRB Processes." On October 1, 2020 and October 19, 2021 subsequent to the submission of the EJR requests, the Board notified you of the relevance of Alert 19 to the EJR requests. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the

[1] The EJR request for 15-1835GC was not filed until October 9, 2020. That case number was included in the reference line of the September 22, 2020 EJR request but the EJR was not uploaded to the Office of Hearings Computer Docketing and Case Management System (OHCDMS) for case number 15-1835GC until October 9, 2020. Until October 9, 2021, Squire, Patton Boggs was not the Group Representative for the appeal and could not file the request for EJR until the change of representative was complete.

above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e*., whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C.§ 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR requests for the above-captioned appeals.

This stay remains in effect. The Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

**Issue:**

The issue under appeal in these cases is:

> Whether the regulations governing outlier payments as set forth in two regulatory sources—(1) the regulations setting the basic payment parameters, including the methodologies and policies adopted for their implementation [42 C.F.R. §§ 412.80-412.86] and (2) the regulations determining the fixed-loss threshold ("FLT"), including methodologies and polices adopted in a given year or in previous years and affecting the FLT (collectively, the Medicare outlier regulations)—as promulgated by the Secretary of Health and Human Services ("HHS") and the Centers for Medicare [&] Medicaid Services [] and as in effect for the appealed years are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid[.][2]

**Statutory and Regulatory Background on Outliers:**

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

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[5] These include hospitals that treat a high percentage of low income patients which receive a percentage add-on payment receive known as

[2] Providers' EJR request at 2.
[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).

the disproportionate share hospital ("DSH") adjustment. Also approved teaching hospitals receive a percentage add-on for cases known as an indirect medical education ("IME") adjustment. In addition, hospitals receive additional payments for cases that involve new technology that is considered a substantial clinical improvement over what is otherwise available.

Relevant here are add-on payments for particular cases that are unusually costly, known as outlier cases, where the IPPS payment is increased. This additional payment is designed to protect hospitals from large financial losses due to unusually expensive cases. [6]

An outlier payment is added to the diagnosis related group ("DRG")[7] adjusted base payment rate, plus any DSH, IME and new technology add-on adjustments.[8] To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold (FLT) (a dollar amount by which the costs of the case must exceed payments in order to qualify for outliers).[9] The Medicare statute, 42 U.S.C. § 1395ww(d)(5)(A), establishes the outlier payment mechanism and states that:

> **(ii)** . . .[a] hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG prospective payment rate, or exceed such other fixed dollar amount, whichever is greater, or, for discharges in fiscal years beginning on or after October 1, 1994, exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F) plus a fixed dollar amount determined by the Secretary.
>
> **(iii)** The amount of such additional payment under clauses (i) and (ii) shall be determined by the Secretary and shall . . .approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).
>
> **(iv)** The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

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[6] 68 Fed. Reg. 10420, 10421 (Mar. 5, 2003).
[7] Prospective payment rates based on Diagnosis Related Groups (DRGs) have been established as the basis of Medicare's hospital reimbursement system. The DRGs are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. *See* https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_ cms/Design_and _development_of_the_Diagnosis _Related_Group_(DRGs).pdf. (last visited 3/3/2021).
[8] 68 Fed. Reg. at 10421.
[9] *Id.* at 10422.

Pursuant to 42 U.S.C. § 1395ww(d)(5)(A)(iv), outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. The statute, 42 U.S.C. § 1395ww(d)(3)(B), requires the Secretary to reduce the average standardized amounts by a factor to account for the *estimated* proportion of the total DRG payments made to outlier cases.[10]

The Secretary implemented the outlier statute through the payment methodology set forth in the regulations at 42 C.F.R. §§ 412.80 through 412.86.

### A. *Changes to the Calculation of Outlier Payments*

In the September 30, 1988 IPPS final rule[11] the Secretary initiated the use of hospital-specific cost-to-charge ratios rather than a nationwide cost-to-charge ratio ("CCR") to determine hospitals costs to determine whether a case qualified for an outlier payment. This change to hospital-specific CCRs was done to ensure that outlier payments were made only for cases that had extraordinary high costs, not just high charges.[12]

In the June 9, 2003 final rule addressing high-cost outliers,[13] the Secretary revised the methodology for determining payments for high-cost outliers. The Secretary explained that recent analysis had determined that some hospitals had taken advantage of two "vulnerabilities" in the outlier methodology "to maximize their outlier payments."[14] One vulnerability was "the time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recent settled cost report."[15] The second vulnerability was that, in some cases, "hospitals may increase their charges so far above costs that their cost-to-charge rations fall below 3 standard deviations from the national geometric mean of cost-to-charge ratios and a higher statewide average cost-to-charge ratio is applied."[16]

The June 9, 2003 final rule revised 42 C.F.R. § 412.84 to implement new regulations to correct these vulnerabilities so that outlier payments are only made for truly high cost cases.[17] As described below, these regulations involve three significant changes to the outlier calculation.

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[10] 68 Fed. Reg. 45345, 45476 (Aug. 1, 2003). 42 U.S.C. § 1395ww(d)(3)(B) states that: The Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).
[11] *See* 53 Fed. Reg. 38476, 38502-38510.
[12] 68 Fed. Reg. at 34495. *See* 71 Fed. Reg. 45870, 48148 (Aug. 18, 2006) (To determine whether the costs of a case exceed the fixed-loss cost threshold, a hospital's CCR is applied to the total covered charges for the case to convert the charges to costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the fixed loss cost threshold. The marginal cost factor for FY 2007 is 80 percent, the same marginal cost factor we have used since FY 1995 [59 Fed. Reg. 45330, 45367 (Sept. 1, 1994)]).
[13] 60 Fed. Reg. 34494 (June 9, 2003).
[14] *Id.* at 34496.
[15] *Id.*
[16] *Id.*
[17] *Id.* at 34515.

### *B. First 2003 Revision to § 412.84 – Use of an Up-to-Date Cost to Charge Ratio*

First, the Secretary instructed the Medicare contractors[18] to use more up-to-date data when determining the cost-to-charge ratio for each hospital through the promulgation of 42 U.S.C. § 412.84(i)(1). The Secretary explained that, under the existing outlier methodology at the time, the cost-to-charge ratios from hospitals' latest settled cost reports were used in determining a fixed-loss amount cost outlier threshold. However, he noted that the Centers for Medicare & Medicaid Services ("CMS") had become aware that, in some cases, hospitals' recent rate-of-charge increases "greatly exceed" their rate-of-cost increases.[19] "Because there is a time lag between the cost-to-charge ratios from the latest settled cost report and current charges, this disparity in the rate-of increases for charges and costs results in cost-to-charge ratios that are too high, which in turn results in an overestimation of hospitals' current costs per case."[20] Therefore, he was revising the outlier payment methodology to ensure that outlier payments are made only for truly expensive cases. [21]

The Secretary pointed out that "[b]ecause the fixed-loss threshold is determined based on hospitals' historic charge data, hospitals that have been inappropriately maximizing their outlier payments have cause the threshold to increase dramatically for FY 2003, and even more dramatically for the proposed IPPS FY 2004 outlier threshold of $50,645 (68 FR 27236, May 19, 2003)."[22] For example, the outlier threshold increased from $9,700 in 1997 to $17,550 in 2001, with another large increase in fiscal year ("FY") 2003 to $33,560.[23] The statute, 42 U.S.C. § 1395ww(d)(2)(E), requires that the average standardized amounts[24] be offset equal to projected outlier payments.[25] As a result of the inappropriate maximization of outline payments, "hospitals that do not aggressively increase their charges do not receive outlier payments or receive reduced outlier payments for truly costly cases."[26]

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[18] Medicare contractors are also known as Medicare administrative contractors ("MACs") and were formerly known as intermediaries or fiscal intermediaries.
[19] *Id*. at 34494.
[20] *Id*.
[21] 68 Fed. Reg. 34494 (June 9, 2003).
[22] *Id*. at 34496.
[23] *Id*.
[24] *See* 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994) ("Section 1886(d)(2)(A) of the Act [42 U.S.C. § 1395ww(d)(2)(A)] required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the September 1, 1983 interim final rule (48 FR 38763) contains a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the prospective payment system and how they are used in computing the Federal rates. . . . The standardized amounts are based on per discharge averages from a base period . . . updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Section 1886(d)(2)(C) and (d)(2)(B)(ii) of the Act required that the updated base-year per discharge costs . . . be standardized in order to remove from the cost data the effects of 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 hospitals serving a disproportionate share of low-income patients.")
[25] 68 Fed. Reg. at 34496.
[26] *Id.* at 34497.

As a result of these issues with outlier payments, the Secretary issued a new regulation, 42 C.F.R. § 412.84(i)(1), that allows Medicare contractors "to use more up-to-date data when calculating the cost-to-charge ratio for each hospital."[27] To this end, it permitted Medicare Contractors to "use either the most recently settled cost report ***or*** the most recent tentative settled cost report, *whichever is from the later cost reporting period*" to update cost-to-charge ratios.[28] The Secretary estimated that this regulation would "reduce[] the time lag for updating the cost-to-charge ratio by a year or more."[29]

The Secretary recognized that even using later cost-to-charge ratios calculated from tentative settle cost reports could over-estimate costs for hospitals that continue to increase their charges much faster than costs during the time between the tentative settlement and the time when a claim is processed. This could be a 1 to 2 year lag during which a hospital's charges may increase faster than charges. As a result, the new regulation specifies that, in the event that more recent changes indicate that a hospital's charges have been increasing at an excessive rate relative to other hospitals, "CMS would have the authority to direct [the Medicare contractor] to change hospital's operating and capital cost-to-charge ratios to reflect the high charge increases evidenced by the later data."[30]

### *C. Elimination of the Use of a Statewide Cost-to-Charge Ratio*

Second, the Secretary implemented new regulation at 42 C.F.R. § 412.84(i)(1) that removed the requirement that a Medicare contractor assign a hospital the statewide average cost-to-charge when the hospital has a cost-to-charge ratio that falls ***below*** an established threshold (3 standard deviations below the national geometric mean cost-to-charge ratio). Under the new regulation, 42 C.F.R. § 412.84(i)(1), hospitals would receive their *actual* cost-to-charge ratio, regardless of how low their ratios fall.[31] **T**he Secretary did not believe there was any justification to continue making outlier payments on the basis of cost-to-charge ratios that "clearly" results in excessive outlier payments.[32]

### *D. Third 2003 Revision to § 412.84 – Using Outlier Reconciliation*

Third, the Secretary added 42 C.F.R. § 412.84(i)(4) and (m) to the regulations to provide that outlier payments for some hospitals would become subject to a "reconciliation" process when a hospital's cost report is settled. In addition, the outlier payments would be subject to an

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[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] *Id.* at 34497-98.
[31] *Id.* at 34500; 68 Fed. 45345, 45478 (Aug. 1, 2003). *See also* 68 Fed. Reg. at 45478 ("The statewide cost-to-charge ratios would still apply in those instances in which a hospital's operating cost-to-charge ratio falls outside of the reasonable parameters (i.e. exceed the upper threshold. In addition, hospitals that have not yet filed their first Medicare cost report with their Medicare contractor would still receive statewide cost to charge ratios. CMS will continue to set the reasonable parameters and the statewide ratios in each year's IPPS rule.")
[32] 68 Fed. Reg. at 34498.

adjustment for the "time value of money" of any underpayments ***or*** overpayments that are reconciled.[33]

Outlier payments, unlike other IPPS payments, are not made on an interim basis, rather they are made on a claim-by-claim basis. Some hospitals which increased their charges at extremely high rates were aware that there would be a lag CCR would be adjusted to reflect the high charges. The Secretary believed that the steps noted above, directing Medicare Contractors to update CCRs using the most recent tentative settled cost report and using actual, rather than statewide average ratios for hospitals with CCRS higher than 3 standard deviations above the geometric mean, would greatly reduce the opportunity for hospitals to manipulate the system to maximize outlier reimbursement. However, this would not eliminate all opportunities. [34]

Consequently, the Secretary added 42 C.F.R. § 412.84(i)(3) to the regulations. This provision provided that, when a cost report was settled, outlier reimbursement would be based on a reconciliation from the cost report and charges computed from the cost report and charge data determined at the time the cost report coinciding with the discharge were settled.[35] Where a provider had received *excess* outlier payments, the provider would be required to reimburse the Medicare Trust Fund and the amount repaid could be adjusted to reflect "the time value of the funds"; the same would be true if there was an *underpayment* of outlier reimbursement by CMS and monies were owed by the Medicare program to the provider.[36]

### *E. Setting the Fixed Loss Threshold for FYE 2005 and Forward*

In response comments received to the FY 2005 IPPS proposed rule recommending a lower fixed loss threshold, the Secretary revised the methodology for determining the outlier fixed loss threshold. The Secretary believed that his revision to the methodology was necessary to address regulatory changes to the outlier payment methodology and the exceptionally high rate of hospital charge inflation in 2001, 2002 and 2003. Because of limited time between the publication of the new regulations and the FY 2004 final rule, the Secretary believed that there was insufficient data to determine the full impact of the regulatory changes on hospital charges. However, as a result of more recent data, the Secretary elected to revise the method for computing the outlier threshold for FY 2005.[37] The Secretary explained that:

> We simulated payments by applying FY 2005 rates and policies using cases from the FY 2003 MedPAR file. Therefore, in order to determine the appropriate FY 2005 threshold, it is necessary to inflate the charges on the MedPAR claims by 2 years, from FY 2003 to FY 2005. Instead of using the 2-year average annual rate

[33] 68 Fed. Reg. at 44476.
[34] *Id.* at 34501.
[35] *Id.* at 34504.
[36] *Id.* at 34501.
[37] 69 Fed. Reg. 48916, 49277 (Aug. 11, 2004).

> of change in charges per case from FY 2001 to FY 2002 and FY 2002 to FY 2003, however, we are using more recent data to determine the annual rate of change in charges for the FY 2005 outlier threshold. Specifically, we are taking the unprecedented step of using the first half-year of data from FY 2003 and comparing this data to the first half year of data for FY 2004. We believe this comparison will result in a more accurate determination of the rate of change in charges per case between FY 2003 and FY 2005. Although a full year of data is available from FY 2003, we do not have a full year of FY 2004 data. We therefore believe it is optimal to employ comparable periods in determining the rate of change from one year to the next. We also believe this methodology is the best methodology for determining the rate of change in charges per case since it uses the most recent charge data available. . . we believe the use of charge inflation is more appropriate than our previous methodology of cost inflation because charges tend to increase at a much faster rate than costs.[38]

The Secretary did not believe that is was necessary to make further specific adjustments to the methodology for computing the outlier threshold to account for any declines in the threshold. This was not necessary since the change from using the data from the most recent final settled cost report to the most recent tentative settled cost report had been implemented.[39] The Secretary did not make any adjustment for possibility that hospitals' cost-to-charge ratios and outlier payments would be reconciled upon settlement believing that there would not be a large fluctuation in the cost-to-charge ratios as the result of the implementation of the 2003 outlier rule changes.[40]

In the FY 2007 final IPPS rule,[41] the Secretary explained that, in earlier years, he had inflated MedPAR claims by calculating a 2-year average annual rate of change in charges per case using the charge data for the two most recent years for which there was relatively complete MedPAR data. As was discussed in the FY 2006 IPPS final rule, he stated that he believed that charge data from FY 2003 may be distorted due to the atypically high rate of hospital charge inflation during FY 2003. Therefore, the Secretary did not inflate charges using the 2-year average annual rate-of-change from FY 2003 to FY 2004 and FY 2005. Instead, the Secretary decided to continue to use a refined methodology that takes into account the lower inflation in hospital charges that is occurring as the result of the FY 2003 IPPS final rule in which the outlier

[38] *Id.*
[39] *Id.*
[40] 70 Fed. Reg. 47278, 47495 (Aug. 12, 2005).
[41] 71 Fed Reg. 47870, 48149 (Aug. 18, 2006).

payment were calculated using more current and accurate cost-to-charge ratios.[42] This change in calculating the outlier payments has continued during the FYs under appeal in this EJR.[43]

**Providers' Position:**

The Providers contend that the Board lacks the authority to decide the legal question of whether the Medicare outlier regulations are contrary to the outlier statute and/or are otherwise substantively or procedurally invalid. The Providers explain that from 1997 through 2003, a small subset of IPPS hospitals greatly inflated their hospital inpatient charges—a practice called "turbo-charging." The hospitals which were turbo-charging their inpatient charges took advantage of the Medicare regulations at the time which computed outlier claims using cost-to-charge ratios that were artificially high or which dropped so low that the higher statewide average was used to determine eligibility for outlier payments. The Providers believe that the high charges multiplied by the inflated cost-to-charge ratios resulted in greatly inflated cost per case and in inflated claims for outlier payments. The Providers point out that from Federal fiscal years 1998 through 2003, the fixed loss threshold was raised roughly ten times the rate of its customary inflation measures: by almost 250 percent compared to the modest cost inflation of 22-26 percent.

The Providers note that, in late 2002, the Secretary[44] stated that: (1) he had learned of the outlier vulnerabilities in the outlier regulations involving critical flaws; (2) other, better data should be used to calculate outlier reimbursement; and (3) outlier payments should be subject to reconciliation. As a result, the Secretary amended the outlier regulations. The Providers contend that in connection with amending the outlier payment regulations, the Secretary could and should have lowered the fixed loss threshold to reflect the new ***post***-turbo-charging regulatory regime. The Providers point to an unpublished interim final rule submitted as Exhibit 9[45] of the EJR request in which the Secretary considered a recommended reduction of the fixed loss threshold immediately to comply with the outlier statute mandates. Rather, the Providers allege that, when the proposed outlier regulations were published in the March 5, 2003 Federal Register,[46] the Secretary omitted key data, other facts, analysis and conclusions from the unpublished interim final rule. The Providers assert that the Secretary disregarded his own provider-favorable conclusions and alternatives and instead used turbo-charged data to set the fixed loss thresholds for FYs 2003-2006. The Providers point out that, when the Secretary did not account for the

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[42] *Id.* at 48149.
[43] *See e.g.* 71 Fed. Reg. 47870, 48148-48153 (Aug. 18, 2006), 72 Fed. Reg. 47130, 47416-47420 (Aug. 22, 2007), 73 Fed. Reg. 48434, 48762-48766 (Aug. 19, 2008), 74 Fed. Reg. 43754, 44007-44012 (Aug. 27, 2009), 75 Fed. Reg. 50042, 50426 (Aug. 16, 2010), 76 Fed. Reg. 51476, 51792-51796 (Aug. 18, 2011), and 77 Fed. Reg. 53258, 53691-53699 (Aug. 31, 2012).
[44] of the Department of Health and Human Services
[45] This unpublished Federal Register Notice was admitted into evidence in *Banner Health v. Sebelius* 945 F. Supp. 2d 1, 19 (D.D.C. 2013) in a ruling on a motion to compel the Secretary to file a complete administrative record. The Court granted the Providers' motion to include the interim rule in the record finding that the Interim Rule contained views adverse to those in Final Rule adopted by the Secretary. The Providers had argued that the interim rule was considered in connection with the 2003 amended outlier regulations.
[46] 68 Fed. Reg. 10420 (Mar. 5, 2003).

decreasing cost-to-charge ratios for the FYs 2004-2006 fixed loss thresholds, the D.C. Circuit in *Banner Health v. Price*[47] remanded the rulemakings.

For the FYs 2007-2013, the Providers believe the unpublished interim final rule continued to be relevant because it contained methodologies that the Secretary knew about, but did not use in setting the fixed loss thresholds. The use of this information, the Providers contend, would have resulted in lower, more accurate fixed loss thresholds. Instead, the Secretary, allegedly set the fixed lost thresholds at a level that substantially underpaid the 5.1 percent target for aggregate outlier payments. Consequently, the Providers did not receive the full amount of outlier payments to which they are statutorily entitled.

Further, in the FY 2007 IPPS final rule, the Secretary stated that he was not going to change any of the methods or policies that had been developed in prior rulemakings to set the fixed loss threshold, including using the most recent recorded cost-to-charge ratios without adjusting them. The Providers contend that the Secretary did not disclose for public comment the fact that he would be adopting a methodology to project the decrease in cost-to-charge ratios to be used as an adjustment factor. In addition, the Providers allege that the Secretary did not disclose, for comment, any of the data and analysis he had used to develop method/policy or disclose the projection of the cost-to-charge ratios he intended to use. Instead, in the FY 2007 IPPS final rule, the Secretary announced that he was projecting decreases in the cost-to-charge ratios, his methodology for doing so, and some of the data upon which he relied. The Providers maintain that the Secretary continued the policy established in FY 2007 during FY 2008-13.

The Providers assert that the Secretary's rulemaking on the FYs 2007-2013 fixed loss threshold polices were substantially and procedurally flawed for a number of reasons:

- The Secretary failed to respond reasonably to public comments that the estimates of prior years' outlier payments were inaccurately high, due to the use of an allegedly flawed methodology and/or data.

- The Secretary failed to use the most current data on hospitals' cost-to-charge ratios to set fixed loss thresholds.

- The Secretary arbitrarily and capriciously refused to account for the impact of reconciliation when setting the fixed loss thresholds, even though he has required to do so by the 2003 payment regulations.

- Relatedly, as he had done during the turbo-charging era, the Secretary continued to include inflated outlier payments resulting from targeted charge increases when calculating the fixed loss threshold.

[47] 867 F. 3d 1323, 1348-53 (D.C. Cir. 2017).

- The Secretary repeatedly failed to publish or otherwise disclose, data and methodologies used or considered in its fixed loss threshold rulemaking even after commenters had specifically requested access to such data.

The Providers contend that, as a result of the above-described substantive and/or procedural errors, the Secretary set the fixed loss thresholds governing the NPRs that are the subject of these appeals in a manner that failed to comply with the statutory mandate to set the outlier payments at least 5 percent of projected DRG payments. The Providers argue that, among other things, the fixed loss thresholds were established in a manner that is arbitrary and capricious, an abuse of discretion or not otherwise in compliance with 5 U.S.C. § 706(2)(A),[48] and/or in excess of the Secretary's jurisdiction under 5 U.S.C. § 706(2)(C).

**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 that comprise these group appeals within this EJR request have filed appeals involving fiscal years 2006-2013.

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 issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[49] 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.[50] On August 21, 2008, new regulations governing the Board were effective.[51] Among the new

[48] The Administrative Procedure Act.
[49] 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.).
[50] *Bethesda*, 108 S. Ct. at 1258-59.
[51] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

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*").[52] 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.[53]

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.

### *B. Jurisdiction and EJR*

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling 1727-R as the Providers are challenging the validity of the fixed loss threshold published in the relevant IPPS final rules for FYs 2006-2013:

> The FLTs [*i.e.*, the fixed loss thresholds] applicable to the claims for which EJR is sought, and as established using the Medicare Outlier Regulations, are substantively and procedurally invalid for numerous reasons . . . .[54]

The Board has determined that the participants involved with the instant EJR request are governed by *Bethesda*. Although Case Nos. 18-1247GC, 18-1248GC and 18-1249GC were established as a CIRP group appeal and are fully formed CIRP groups, they only have a single participant and the Board is electing to treat the cases as individual appeals.[55] These appeals

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[52] 201 F. Supp. 3d 131 (D.D.C. 2016).
[53] *Id.* at 142.
[54] EJR Request at 4.
[55] The Board notes that, as with any fully-formed CIRP group, the following statement in 42 C.F.R. § 405.1837(e) is applicable: "When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, *no other provider* under common

were timely filed and the $10,000 amount in controversy for an individual appeal has been met.[56] Finally, the remaining 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 Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

The Board finds that it lacks the authority to grant the relief sought by the Providers, namely a finding that that the underpayment of the outlier calculation for FFY 2006-2013 is not valid. Consequently, the Board finds that EJR is appropriate.

### *C. Board's Decision Regarding the EJR Request*

The Board finds that:

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

2) Based upon the participants' assertions regarding validity the outlier rates published in the IPPS final rules for FYs 2006-2014, 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 following fixed loss thresholds ("FLTs") that were published in the Federal Register and relevant to the fiscal years at issues for the participants in the these group appeals are procedurally and/or substantively valid. The federal fiscal years relevant to these group appeals (based on the fiscal years appealed by the participants) are 2006 through 2014 and, accordingly, the FLTs published and finalized in the following IPPS final rules are being challenged:

    - FY 2006 IPPS Final Rule, 70 Fed. Reg. 47278, 47493-96 (Aug. 12. 2005);
    - FY 2007 IPPS Final Rule, 71 Fed. Reg. 47870, 48148-52 (Aug. 18, 2006);
    - FY 2008 IPPS Final Rule, 72 Fed. Reg. 47130, 47416-20 (Aug. 22, 2007);
    - FY 2009 IPPS Final Rule, 73 Fed. Reg. 48434, 48762-66 (Aug. 19, 2008);
    - FY 2010 IPPS Final Rule, 74 Fed. Reg. 43754, 44007-12 (Aug. 27, 2009);
    - FY 2011 IPPS Final Rule, 75 Fed. Reg. 50041, 50426-31 (Aug. 16, 2010);
    - FY 2012 IPPS Final Rule, 76 Fed. Reg. 51476, 51792-96 (Aug. 18, 2011);

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ownership or control *may appeal to the Board the issue that is the subject of the group appeal* with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal." (Emphasis added.)

[56] 42 C.F.R. § 405.1835(a).

[57] *See* 42 C.F.R. § 405.1837.

- FY 2013 IPPS Final Rule, 77 Fed. Reg. 53258, 53691-99 (Aug. 31, 2012); and
- FY 2014 IPPS Final Rule, 77 Fed. Reg. 50496, 50977-85 (Aug. 19, 2013).

Accordingly, the Board finds that the question of the validity the fixed loss thresholds published in the IPPS final rules for FY 2006-2014 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 the cases.

Board Members Participating:

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

FOR THE BOARD:

5/14/2021

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Bruce Synder, Novitias Solutions
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Stephanie Webster, Esq.
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RE: ***Expedited Judicial Review Determination***
14-1355GC Southwest Consulting/Carilion Clinic 2009 DSH Medicaid Fraction Part C Days
14-1359GC Southwest Consulting/Carilion Clinic 2009 DSH SSI Fraction Part C Days

Dear Ms. Webster:

The above-referenced common issue related party ("CIRP") group appeals[1] includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On April 23, 2021 the Providers in the above-referenced CIRP group appeals filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Request, and then grant it in part and deny it in part, is set forth below.

## Statutory and Regulatory Background

### *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 . . ."

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).

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[2] 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].[3]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[4]

With the creation of Medicare Part C in 1997,[5] 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 years 2001-2004.[6]

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:

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[2] of Health and Human Services.
[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*
[5] 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.
[6] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

> . . . 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 . . . .*[7]

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."[8] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[9]

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.[10] 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).[11] As a result of these rulemakings, Part C days were

[7] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[8] 69 Fed. Reg. at 49099.
[9] *Id.* (emphasis added).
[10] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[11] *Id*. at 47411.

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."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] 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.[14] In *Allina Health Services v. Price* ("*Allina II*"),[15] 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*.[16] 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.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

*CMS Ruling 1739-R*

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The

[12] 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).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] *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.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

Regarding EJRs for this Issue, and the fate of these appeals, the Ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[22]

[21] *Id*.
[22] CMS Ruling 1739-R at 6-7.

**Providers' Request for EJR**

The Providers point out that the Secretary has not acquiesced to the decisions in *Allina I*[23] and *Allina II*[24] which decided how Medicare Part C Days would be treated in the DSH calculation. The Providers contend that the allegedly uncorrected DSH payment determinations applying the now-vacated rule as though it is still valid not only violates the explicit terms of the *Allina* decisions, but also violates the procedural requirements of the Medicare Act, 42 U.S.C. § 1395hh(a), and the Administrative Procedure Act ("APA"), 5 U.S.C. § 553. The Providers seek corrections of those determinations. In addition to the Part A/SSI fractions published based on this rule, the Providers point out that the Secretary has "left on the books"[25] the vacated 2004 rule itself, which the Board is bound to apply under the provisions of 42 C.F.R. § 405.1867. Thus, the Providers believe the Board has jurisdiction over the appeals but lacks the authority to grant the relief sought by the Providers; consequently, the Board is required to grant EJR.

The Providers maintain that recent developments reinforce the Board's lack of authority to resolve the issue and the need for EJR. The agency's proposed rule to re-adopt the 2004 policy change retroactively, is still only a proposal at this point. If the Agency adopts this proposal as final, which the Providers believe CMS Ruling 1739-R seems to presume would occur in claiming that the pending appeals are now "moot," the payment determinations from which the Providers have appealed would be left undisturbed (and potentially not subject to appeal). The Providers assert that CMS Ruling 1739-R calls for the Board to determine its jurisdiction over Part C appeals, and does not and cannot override the Board's obligation to make determinations as to its authority to decide legal questions. In any event, the Providers assert, the Ruling is invalid as it otherwise violates the clear requirements of the Medicare statute and regulations, which the agency cannot circumvent by issuing a ruling.

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[26]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the

[23] *Allina Health Servs. v. Sebelius*, 746 F. 3d 1102 (D.C. Cir. 2014) (*Allina I)*.
[24] *Allina Health Servs. v. Price,* 863 F. 3d 937 (D.C. Cir. 2017), aff'd *Azar v. Allina Health Servs.* 139 S. Ct. 1804 (2019) ("*Allina II"*).
[25] Provider's EJR request at 1.
[26] *Id*. at 14.

> Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[27]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[28]

The Providers also maintain that the Board has jurisdiction over the Providers' challenge to the validity and proper application of CMS Ruling 1739-R as part of the matter at issue. The Providers argue that while the Ruling ordered the Board to remand otherwise jurisdictionally proper appeals of the Part C days issue, is does not by its terms deprive the Board of jurisdiction over the challenges to the actual validity of the ruling. The Providers believe the Board has correct in its decision in *Southwest Consulting 2004 DSH Dual Eligible Days Group et al. v. Blue Cross Blue Shield Association*[29] when it found in the context of analogous CMS Ruling 1498-R,[30] "EJR is appropriate to determine the validity in [the Ruling] that would, if valid, deprive the Board of jurisdiction and thereby prohibit it from granting EJR as to the validity of other substantive provisions [of the Ruling]."[31] Accordingly, the Board was correct when it concluded it has jurisdiction over appeals that challenge the validity of CMS Ruling 1739-R in earlier cases that challenged the validity of Ruling 1798-R.[32]

The Providers contend that because the Secretary has not acquiesced in the decisions of D.C. Circuit and Supreme Court, the Board remains bound by the 2004 DSH rule, and thus, still lacks the authority to grant the relief sought from the determinations applying the 2004 rule. Further, to the extent that the CMS Ruling 1739-R effects whether the Board can adjudicate the

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[27] *Id*. at 14.
[28] *Id.* at 13.
[29] PRRB Dec. 2010-D35 (2010 WL 4214212 (PRRB) (June 14, 2010)).
[30] The Ruling is found on the internet at: https://www.cms.gov/regulations-and-guidance/guidance/rulings/downloads/cms1498r.pdf.
[31] PRRB Dec. 2010-D35 at 5.
[32] *Id. at 13.*

Providers' claims regarding the treatment of Part C days in the Medicare DSH payment adjustment, the issue is properly part of this appeal. Consequently, the Board should also grant EJR over both matters.

**Board's Analysis and Decision**

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP group and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that, as of August 17, 2020, divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after these groups were established).

*Board's Authority*

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Board's analysis is detailed below.

*Jurisdictional Requirements for Providers*

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[33,34]

[33] 42 C.F.R. § 405.1835(a).
[34] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

With respect to the "dissatisfaction" prong of the Board's jurisdiction regulation, for cost report periods ending prior to December 31, 2008, a provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[35] 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.[36]

On August 21, 2008, new regulations governing the Board were effective.[37] 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*").[38] 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.[39]

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 ("CMS 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods that ended on or after December 31, 2008, and began before January 1, 2016, that were pending or filed on or after April 23, 2018.[40] Under this Ruling, if 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) is no longer applicable. However, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.[41]

The Providers included in the instant EJR request filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending

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[35] 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.).
[36] *Bethesda* at 1258-59.
[37] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[38] 201 F. Supp. 3d 131 (D.D.C. 2016).
[39] *Banner* at 142.
[40] CMS Ruling CMS-1727-R at 1-2.
[41] *Id*. at unnumbered page 7.

in 2009 and are governed by CMS Ruling CMS-1727-R.[42] The Board further finds that the Providers appeals are permitted under the dictates of CMS-1727-R because they self-disallowed their claims based on the regulation at issue and are challenging the validity of that regulation.

Finally, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000 as required for a group appeal.[43] 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.

*Medicare Part C Days Issue*

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[44] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[45] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[46] To date, CMS has yet to issue its new final rule.[47]

As the Providers' appeals concern the FY 2009 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[48] Accordingly, the

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[42] 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.
[43] *See* 42 C.F.R. § 405.1837.
[44] (Emphasis added.)
[45] CMS Ruling 1739-R at 1-2.
[46] Id. at 2.
[47] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[48] (Emphasis added.)

Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

*Validity of CMS Ruling 1739-R*

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[49]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[50] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in

[49] EJR Request at 17.

[50] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

> resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[51]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [52] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[53]

As noted prior, the Board must grant EJR 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.[54] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that, as of August 17, 2020, purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

**Conclusion**

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeal (*i.e.*, the appeals are jurisdictionally proper);

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Providers will receive a remand letter of this issue under separate cover; and

3) The Board hereby **grants** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that, as of August 17, 2020, divests the Board

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[51] *See Southwest* at 6-7.
[52] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[53] *See* CMS 1739-R at 8.
[54] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeals.

Board Members Participating:

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Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

5/18/2021

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Dana Aylward
Besler Consulting
3 Independence Way, Ste. 200
Princeton, NJ 08540

RE: ***Request for Expedited Judicial Review***
Besler Consulting CY 2016 Medicaid Expansion Days Group
Case No. 19-1618G

Dear Ms. Aylward:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 15, 2020 request for expedited judicial review ("EJR") in the above-referenced appeal. The Board's decision with respect to the EJR request is set forth below.

**Effect of COVID -19 on Board Operations**

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes."

On July 23, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

The stay remains in effect as the Board has not resumed normal operations. In this regard, the Board is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

## Issue

The Providers in this group seek "to include in their second disproportionate share hospital (DSH) computation additional days attributable to individuals who were made 'eligible' for Medicaid under the Medicaid expansion provisions of the Affordable Care Acts of 2010, adding 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)."[1]

## Background

On July 15, 2020, the Providers filed this EJR request, and it was automatically stayed under the Board's Alert 19 policy (as confirmed by the Board's July 23, 2020 notice for this case). As further explained below, the hospitals in this case are located in States which did not expand their Medicaid programs under the relevant provisions of the Patient Protection and Affordable Care Act of 2010 but wish to include individuals who would have been eligible for Medicaid under the expansion provisions in the Medicaid fraction of the DSH calculation.

### *A. Medicare DSH Payment*

Part A of the Medicare Program 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, the Medicare Program 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] This case involves 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

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[1] Groups' Brief in Support of Request for Expedited Judicial Review, 1 (Nov. 25, 2020).
[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), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> 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 and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[11]

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]

### *B. The Affordable Care Act – Medicaid Expansion Provisions*

The Patient Protection and Affordable Care Act[13] was amended by the Health Care and Education Reconciliation Act of 2010,[14] and *together* these laws are referred to as the Affordable Care Act ("ACA"). In addition, § 205 of the Medicare & Medicaid Extenders Act of 2010[15] made technical corrections to the Social Security Act ("the Act") to implement the ACA.[16] The purpose of this legislation was to increase the number of Americans covered by health insurance and decrease the cost of healthcare.[17] The laws enacted under this statute affected many aspects of health care coverage including the Medicaid Program which is authorized under Title XIX of the Act and was enacted in 1965 along with the Medicare Program which is authorized under

[9] (Emphasis added.)
[10] 42 C.F.R. § 412.106(b)(2)-(3).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(4).
[13] Pub. L. 111-148, 124 Stat. 119 (2010).
[14] Pub. L. 111-152, 124 Stat. 1029 (2010).
[15] Pub. L. 111-309, 123 Stat. 3285 (2010).
[16] 77 Fed. Reg. 17444, 17145 (Mar. 23, 2012).
[17] *National Federation of Independent Business et al. v. Sebelius,* 567 S.Ct. 519 (2012).

Title XVIII of the Act. All states, the District of Columbia, and U.S territories have each implemented a Medicaid program for its respective territory that provides health coverage to low income people.[18] Relevant here are the Medicaid expansion provisions which added 42 U.S.C. § 1396a(a)(10)(A)(VII). This statute states that:

> A State plan for medical assistance must—
>
> *****
>
> (10) provide—
> (A) for making medical assistance available, including at least the care and services . . . of this title to—
>
> (VIII) beginning January 1, 2014, who are under the 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under Part A of subchapter XVIII, or enrolled for benefits under Part B of subchapter XVIII, and are not described in a previous subclause of this clause, and whose income . . . does not exceed 133 percent of the poverty line. . . applicable to a family of the size involved. . . .

In conjunction with the expansion of the Medicaid eligible beneficiaries described above, 42 U.S.C. § 1396c (Operations of State Plans) penalized States which did not expand their Medicaid programs. This statute requires, as a general rule, that:

> If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—
>
> (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision;
>
> the Secretary shall *notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply*. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).[19]

[18] *See* http://www.Medicaid.gov/about-us/program-history/index.html (last visited January 4, 2021).
[19] 42 U.S.C. § 1395c (emphasis added).

Essentially, under this statute, States which failed to comply with the Medicaid expansion mandate could lose part or all of their Federal funding for Medicaid.

### *C. Supreme Court Litigation on ACA*

Numerous states and the National Federation of Independent Businesses challenged in the federal court system, two provisions of ACA – the individual mandate[20] and the Medicaid expansion. The Supreme Court ultimately addressed these issues in *National Federation of Independent Businesses v. Sebelius* ("*NFIB*").[21] Relevant to the issue before the Board is the Court's decision with respect to Medicaid expansion.

In *NFIB,* the Court noted that the Medicaid expansion provisions of ACA required States to expand their Medicaid programs no later than 2014 to cover all individuals under age 65 with incomes below 133 percent of the federal poverty line.[22] Further, ACA provided that the expanded Medicaid benefits would include benefits sufficient meet the requirements of the individual mandate.[23] The Federal Government would initially pay 100 percent of the costs through 2016, with payments gradually deceasing to a minimum of 90 percent.[24] However, the States argued that the Medicaid expansion exceeded Congress' authority under the Spending Clause. They claimed Congress was coercing the States to adopt the changes by threatening to withhold all of a State's Medicaid grants unless the States accept the new conditions.[25]

The Supreme Court found that the Medicaid expansion portion of ACA violated the Spending Clause of the Constitution by threatening existing Medicaid funding. The Court explained that Congress does not have the authority to order States to regulate according to its instructions. Rather, Congress could offer grants to States, but the States must have a choice whether to accept the offer. To remedy this, the Supreme Court precluded the Federal Government from applying the penalty at 42 U.S.C. § 1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion and specifically noted that "[t]he remedy does not require striking down other portions of the Affordable Care Act."[26]

**Providers' EJR Request:**

The Providers' Issue Statement submitted with the initial appeal argues that the interplay between these ACA provisions and the Supreme Court's *NFIB* decision create a statutory scheme wherein the definition of individuals who are "Medicaid eligible" was greatly and uniformly expanded throughout the nation, but certain states declined to extend Medicaid benefits to this otherwise expanded population. Thus, this new group is, by statute, "Medicaid eligible," but in practice were not "covered under a state medical assistance plan." They claim

[20] *See* 26 U.S.C. § 5000A.
[21] 567 U.S. 519 (2012).
[22] *Id.* at 576 (citing 42 U.S.C. § 1396a(10)(A)(i)(VIII)).
[23] *Id.* The individual mandate is found at 42 U.S.C. §§ 1396a(k)(1), 1396u-7(b)(5), and 18022(b)).
[24] *Id.*
[25] *Id.* at 575.
[26] *Id.* at 588.

that the Medicaid fraction has "repeatedly and uniformly been construed to require" inclusion of days of persons qualifying for medical assistance, regardless of whether a state actually pays for or covers those days under its medical assistance plan.

The Providers point out that the Secretary's regulations at 42 C.F.R. § 412.106(b)(4) related to the calculation of the Medicaid fraction recognize that days of persons eligible for medical assistance should be included, but refers to ***only*** those days of persons eligible "under an approved State Medicaid plan." This excludes those days for patients who are statutorily designated as "Medicaid eligible" pursuant to 42 U.S.C. § 1396a(a)(10)(A)(VII), but reside in a state that did not expand its medical assistance program to cover them as permitted via the *NFIB* decision (despite the directive found in 42 U.S.C. § 1396c).[27]

The Providers seek to have the Board "recognize the right of hospitals located in non-expansion States to count inpatient days for persons who qualify for Medicaid under the income test of [42 U.S.C. § 1396a(a)(10)(A)(VII)] as statutorily mandated low-income days, even if, in the case of hospitals located within a non-expansion State, those days are *not* 'covered or paid [for] under the State plan.'"[28]

The Providers claim that the definition of, and formula for, the Medicaid fraction found at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) describes days for persons who were "eligible for medical assistance" which has long been judicially recognized as referring to technical eligibility for Medicaid, rather than the actual payment of benefits by a state Medicaid program.[29] Providers insist that, in enacting the ACA, Congress not only expanded medical assistance eligibility, but intended that any patient days for this expanded group would be included in the Medicaid fraction.[30] Indeed, Providers claim that, prior to the *NIFB* decision, this was CMS' expectation, as well.[31] The Supreme Court's decision in *NFIB* did not alter the statutory designation of "Medicaid eligibility" for this expanded population, but merely provided that states could not be penalized if they did not actually cover or actually pay benefits for them.[32] Thus, the Providers conclude that the exclusion of these days from non-expansion states' Medicaid fractions is invalid and unconstitutional. Since they are challenging the validity and constitutionality of the Secretary's regulations *as applied to non-expansion state hospitals*, the Providers believe the Board lacks the authority to grant the relief they seek. As such, they are requesting the Board grant EJR over the Providers in this group.[33]

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[27] Issue Statement.
[28] Group's Brief in Support of Request for Expedited Judicial Review at 4 (July 15, 2020) ("EJR Request").
[29] *Id.* at 11-12 (citing *Emanuel Hosp. and Health Ctr. v. Shalala*, 97 F.3d 1261, 1264 (9th Cir. 1996); *Jewish Hosp. Inc. v. Secretary of HHS*, 19 F.3d 270, 274-75 (6th Cir. 1994); *Deaconess Health Servs. Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996)). *See also Forest Gen. Hosp. v. Azar*, 926 F.3d 221, 228-229 (5th Cir. 2019); *Empire Health Foundation v. Azar*, 958 F.3d 873 (9th Cir. 2020).
[30] EJR Request at 13-14.
[31] *Id.* at 15-16.
[32] *Id.* at 16 (citing *Alaska Legislative Council v. Walker*, Case No. 3A??N-15-09208 CI, Slip. Op. at 12 (Alaska Super. Ct., Mar. 1, 2016) ("*NFIB* created a unique situation where, for the first time, the Social Security Act textually commends states to cover a group but it does not penalize noncomplying states.").
[33] *Id.* at 23.

## 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), 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 group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [34]
- The matter at issue involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[35]

### *A. Jurisdiction: Revised NPRs*

The Medicare Contractor filed a Jurisdictional Challenge on March 1, 2021 noting that UF Health Jacksonville was directly added to the group *based on appeals from two separate final determinations*: an original NPR and a revised NPR. The Medicare Contractor asks the Board to dismiss the appeal from the revised NPR because there was no specific adjustment to Medicaid expansion days or removal of a related protested item.

Regarding appeals from revised NPRs, 42 C.F.R. § 405.1889(a) (as revised May 23, 2008) explains that a revised NPR "must be considered a separate *and* distinct determination." Further, § 405.1889(b) explains that, as a prerequisite for Board jurisdiction, the issue on appeal must have been "specifically revised."[36] To this end, 42 C.F.R. § 405.1835(a) specifies that the right to appeal a final determination reopened under § 405.1885 "must be limited ***solely*** to those matters that are specifically revised in the contractor's revised final determination" and cross-references § 405.1889(b).[37]

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[34] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[35] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[36] 42 C.F.R. § 405.1885, 1889 (following August 21, 2008) ("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." (emphasis added)).
[37] (Emphasis added.)

The sole adjustment for UF Health Jacksonville's appeal from its revised NPR is not related to Medicaid Expansion Days much less the Medicaid fraction as used in the DSH adjustment calculation (*i.e*., there was no adjustment that "specifically revised" the matter at hand). Rather, as noted in the notice of reopening, the RNPR was issued "[t]o include WS S-10 Adjustments." As such, this Provider has no appeal rights under 42 C.F.R. §§ 405.1889(b) as referenced by 405.1835(a)(1) to appeal the Medicaid expansion issue from its revised NPR and, as a consequence, the Board hereby dismisses UF Health Jacksonville's revised NPR from this case. *Notwithstanding, the Board notes that it still retains jurisdiction over UF Health Jacksonville's appeal from its original NPR*.

***B. Appropriate Cost Report Claim Analysis: 42 C.F.R. §§ 413.24(j) and 405.1873***

On February 8, 2021, the Board requested additional information from the Group Representative regarding the only two participants in the appeal that were subject to 42 C.F.R 413.24(j). Specifically, the Board asked for both parties to review and supplement the record if necessary with additional evidence or argument for the following two participants:

- Springhill Memorial Hospital (01-0144) ("Springhill")
- Bryan Medical Center (28-0003) ("Bryan")

Both the Medicare Contractor and the Group Representative responded to that request on March 1, 2021. Neither party requested that the Board conduct any oral proceedings on the Substantive Claim Challenge.[38]

1. Regulatory Background

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, 413.24(j) requires that:

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the

[38] In its February 8, 2021 request for information, the Board advised the parties: "If a party desires to have additional evidence or argument considered (e.g., testimony or oral arguments), **that party must submit a request to the Board with both a description of and an explanation of the need for such additional evidence/argument (whether written or oral).** Otherwise, following the above referenced filing deadline, the Board will proceed with issuing a ruling on the § 413.24(j) compliance issue(s) based solely on the record before it." (Emphasis in original.)

> provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[39]

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.
>
> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny,**

[39] (Bold and underline emphasis added.)

> **or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[40]

These regulations are applicable to the cost reporting period of two group participants in this case. Position papers have not been filed, but following the Board's February 8, 2021 Request for Information, the parties submitted briefs with regard to whether the two Providers included an appropriate cost report claim for the disputed issue.

[40] (Bold and underline emphasis added.)

2. Medicare Contractor's Argument

The Medicare Contractor claims that both Springhill and Bryan "did not claim reimbursement for the Medicaid expansion days in their cost reports in accordance with Medicare policy nor did the Providers self-disallow the specific item in their respective cost report."[41]

For both Springhill and Bryan, the Medicare Contractor notes that, while adjustments were made to remove the entire protested amounts from their as-filed cost report, the listing of self-disallowed items encompassed by those protested amounts did not include any items for additional Medicaid expansion days.[42] The Medicare Contactor also claims that no other adjustments were made related to Medicaid expansion days, and that none of the exceptions in 42 C.F.R. § 413.23(j)(3)(i) through (iii) of the regulation apply.[43]

3. Group Representative's Response

The Group Representative first preserved its objection to the new substantive claim regulations as being invalid. With regard to Springhill, the Group Representative notes that Springhill's protested item worksheets included an item reading "that CMS's continued reliance on allocating the Uncompensated Care Payments (UCP) using empirical DSH factors has arbitrarily diluted the UCP that should be received by providers in States where Medicaid expansion has not been implemented."[44]

For Bryan, the Group Representative argues that Bryan formally protested the Uncompensated Care calculation used to determine its DSH payment, which would necessarily include costs for charity care, including patients eligible for Medicaid expansion under the ACA that are the subject of this appeal. It acknowledges that it "did not specifically mention" Medicaid expansion days in its protest worksheets, but argues "that omission is irrelevant for purposes of determining Board jurisdiction in connection with the Group's EJR petition, as the 2015 Regulations were reframed so that the failure to protest is a substantive issue that becomes germane at the relief stage, and can no longer serve to deprive the PRRB of jurisdiction."

4. Appropriate Cost Report Claim: Findings of Fact and Conclusions of Law

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[45] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting

[41] Medicare Administrative Contractor Substantive Claim Letter at 4 (Mar. 1, 2021)
[42] Exhibit C-2 at 10-12; Exhibit C-3 at 11.
[43] Medicare Administrative Contractor Substantive Claim Letter at 4-6.
[44] Provider's Response to Request for Information at 3-4 (Mar. 1, 2021).
[45] (Emphasis added.)

EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

a) Springhill

The Board finds that Springhill ***failed*** to include "an appropriate claim for the ***specific*** item"[46] under appeal in this group -- the Medicaid Expansion Days issue. During the fiscal year at issue, 42 U.S.C. § 1395ww(r) specifies that the Medicare payment to a DSH hospital consists of two payments. The first payment is referred to as the "empirically justified Medicare DSH payment" and consists of "25 percent of the amount that the hospital would have received under [42 U.S.C. § 1395ww(d)(5)(F)] for DSH payments, which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to Congress."[47] The second payment is referred to as the "uncompensated care payment" and is an amount equal to the product of the following three factors specified in 42 U.S.C. § 1395ww(r)(2):

> Factor 1 –75 percent of the Secretary's estimate of Medicare DSH payments that, in the absence of § 1395ww(r), would otherwise be made under § 1395ww(d)(5)(F) for the fiscal year;
>
> Factor 2 – 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured; and
>
> Factor 3 – "[A] percent that, for each subsection (d) hospital, represents the quotient of the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data), including the use of alternative data where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, and the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under [42 U.S.C. § 1395ww(r)]."[48]

Significantly, 42 U.S.C. § 1395ww(r)(3) specifies the following "limitations on review" relative to all UCP three factors:

> There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of the following:
>
> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

[46] 42 C.F.R. § 405.1873(a).
[47] 80 Fed. Reg. 49326, 49513 (Aug. 17, 2015).
[48] *Id.* at 49514.

(B) Any period selected by the Secretary for such purposes.

The protested items do include one line item pertaining to UCP and this item involves States where Medicaid expansion was not implemented:

> **Uncompensated Care Payments -**
> **States electing no Medicaid Expansion** **$10,000**
>
> The provider believes that CMS's continued reliance *on allocating the Uncompensated Care Payments (UCP)* using empirical DSH factors (Medicaid patient days and the Medicare SSI%) has arbitrarily diluted the UCP that should be received by providers in States where Medicaid expansion has not been implemented. The Medicaid proxy factor between States is no longer comparable due to this expansion issue and *should not be utilized as a proxy measure for the UCP allocation*. CMS's deferral to rely on the worksheet S-10 data to perform an UCP allocation is negatively impacting non-expansion States.[49]

Significantly, the protested item seeks to ***remove*** use of the Medicaid proxy for purposes of ***UCP*** allocation. The issue was filed under protest and the Medicare Contractor removed the protested line item from the Springhill Memorial Hospital's cost report.

As noted in the preamble to the FY 2016 IPPS Final Rule, the DSH payment is separate from the UCP payment and this is borne out in the statute where the DSH payment is provided for in 42 U.S.C. § 1395ww(r)(1)[50] and the "additional" UCP payment is provided for in 42 U.S.C. § 1395ww(r)(2). Accordingly, the Board finds that the protested item does not encompass the group's ***DSH***-related issue. Rather, it ***only*** pertains *to the UCP* which is precluded from administrative review per 42 U.S.C. § 1395ww(r)(3).[51] In making this finding, the Board notes that the Provider had an obligation under 42 C.F.R. § 413.424(j)(1) to "include an appropriate claim for the ***specific*** item"[52] and, here, Springhill failed to make a claim for the "specific item,"

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[49] (Italics and underline emphasis added.)
[50] *Id.* at 49513.
[51] The D.C. Circuit has reviewed the statutory limitation on review several times. *See Florida Health Servs. Inc. v. Secretary of HHS*, 830 F.3d 515 (D.C. Cir. 2016); *DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503 (D.C. Cir. 2019).
[52] The Board notes that "specific item" is the same language used in following excerpt from 42 C.F.R. § 405.1835(b) entitled "Contents of request for a Board hearing on final contractor determination": "The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate. . . . (2) For each ***specific item*** under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following: (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does

namely the ***DSH*** Medicaid fraction as it relates to Medicaid Expansion Days.[53] Based on the above, the Board finds that Springhill failed to specifically include a substantive claim for the group's DSH Medicaid Expansion Days issue as required under 42 C.F.R. § 413.424(j)(1).

b) Bryan Medical Center (Prov. No. 28-0003)

For Bryan, the Board similarly finds that this Provider did ***not*** include an appropriate cost report claim for the Medicaid Expansion Days issue. Bryan filed a number of items under protest. Protested items connected to the DSH adjustment payment include:

- "DSH Impact for proper reimbursement Dual Eligible, Medicare, Medicare Non-Covered days, other";
- "SSI proper number for reimbursement Hospital and Rehab SSI"; and
- "Medicare/Medicaid Days in SSI."[54]

Of the above, only the first potentially relates to the group issue. However, 42 C.F.R. § 413.24(j)(2) specifies:

> (1) In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) ***and*** **describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[55]

Here, the only protested item that potentially relates to the DSH Medicaid fraction ***fails*** to "explain[] why the provider self-disallowed each specific item (instead of claiming full

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not have access to underlying information concerning the calculation of its payment). (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item. (iii) *If the provider self-disallows a* ***specific item*** *(as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item*."

[53] This finding is further supported by the fact that the protested item is seeking ***removal*** of the Medicaid fraction from consideration in the ***UCP*** *calculation* while, in the contrast, the group appeal is seeking ***expansion*** of the Medicaid fraction (*i.e*., by including days for Medicaid expansion in states that did not elect to implement Medicaid expansion) in the ***DSH*** calculation.

[54] *See* the Protested Item Support Documentation filed with Bryan Medical Center's direct add request.

[55] (Emphasis added.)

reimbursement in its cost report for the specific item)" or "describ[e] how the provider calculated the estimated reimbursement amount" for the protested item." Indeed, there is no indication that any of Bryan's protested items relate to the group's DSH Medicaid Expansion Days issue. Based on the above, the Board finds that Bryan failed to specifically include a substantive claim for the group's DSH Medicaid Expansion Days issue as required under 42 C.F.R. § 413.424(j)(1).

### *C. Jurisdiction and Appropriate Cost Report Claim Summary for the Remaining Participants*

There are seven remaining participants as noted on the attached Schedule of Providers (*i.e.*, UF Jacksonville Health's appeal from the revised NPR is not included as a remaining participant). The remaining participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[56] The remaining participants' appeals were all timely filed and all of the remaining participants with cost reporting periods beginning *before* January 1, 2016 protested the Medicaid Expansion Days issue or appealed from the failure to issue a timely final determination.[57] For the two remaining participants with cost reporting periods *beginning on* January 1, 2016, the Board notes that whether the Medicaid Expansion Days issue was protested or appropriately claimed on their cost reports does not impact whether the Board has jurisdiction over their appeals, but the Board has included its findings of facts and conclusions of law in this regard, *supra*.

Based on the above, the Board finds that it has jurisdiction for this appeal and the seven (7) remaining participants, as noted above. Furthermore, since the remaining 7 participants are challenging the validity of 42 C.F.R. § 412.106(b), as it relates to including Medicaid Expansion Days in the Medicaid fraction, the Board lacks the authority to provide the relief sought by these Providers.

## **Board's Decision Regarding the EJR Request**

The Board finds that:

1) It has jurisdiction over the subject and years of the group appeal and that the participants in this group appeal are entitled to a hearing before the Board with the exception of UF Health Jacksonville's (10-0001) appeal from its revised NPR;

2) The following two participants appealed cost reporting periods beginning on January 1, 2016 but failed to include "an appropriate claim for the specific item" that is the subject of the group appeal as required under 42 C.F.R. § 413.24(j)(1):

   - Springhill Memorial Hospital (01-0144), and
   - Bryan Medical Center (28-0003);

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[56] *See* 42 C.F.R. § 405.1837.
[57] Dissatisfaction is not required when appealing untimely contract determinations. *See* 79 Fed. Reg. 49853, 50200 (Aug. 22, 2014).

3) Based upon the participants' assertions regarding inclusion of Medicaid Expansion Days in the Medicaid Fraction of the DSH formula, there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal question of whether the definition of "eligible for Medicaid" in 42 C.F.R. § 412.106(b)(4), which implements, in part, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), is invalid because it fails to include individuals who "are mandatorily 'eligible' for Medicaid as a matter of federal statutory law [at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) as added by ACA § 2001(a)], yet are not 'covered under a state medical assistance plan' in states electing to forego expanded coverage without penalty in light of the [Supreme Court's] decision in *NFIB*."[58]

Based on the above findings, the Board concludes that the above question concerning the validity of 42 C.F.R. § 412.106(b)(4) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and that the Board lacks the authority to provide the relief sought by the Providers (*i.e.*, to include in the Medicaid fraction of the DSH adjustment calculation those days attributable to individuals who "are mandatorily 'eligible' for Medicaid as a matter of federal statutory law [at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) as added by ACA § 2001(a)], yet are not 'covered under a state medical assistance plan' in states electing to forego expanded coverage without penalty in light of the [Supreme Court's] decision in *NFIB*." [59]). Accordingly, the Board 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, the Board hereby closes the case.

Board Members Participating:

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

For the Board:

5/18/2021

X Clayton J. Nix

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

Enclosures: Schedule of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong. Esq., FSS

[58] EJR Request at 2-3.
[59] *Id.* at 2-3.

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
7500 Security Boulevard
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Baltimore, MD 21244
410-786-2671

**Via Electronic Delivery**

Michael Newell
Southwest Consulting Associates
2805 North Dallas Parkway
Plano, TX 75093-8724

RE: ***Expedited Judicial Review Determination***
15-2073GC Southwest Consulting/Carilion Clinic 2010 DSH Medicaid Fraction Part C Days Grp
15-2075GC Southwest Consulting/Carilion Clinic 2010 DSH SSI Fraction Part C Days Group

Dear Mr. Newell:

The above-referenced common issue related party ("CIRP") group appeals[1] includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On April 26, 2021 the Providers in the above-referenced CIRP group appeals filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Request, and then grant it in part and deny it in part, is set forth below.

## Statutory and Regulatory Background

### *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 . . ."

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).

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[2] 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].[3]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[4]

With the creation of Medicare Part C in 1997,[5] 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 years 2001-2004.[6]

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:

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[2] of Health and Human Services.
[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*
[5] 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.
[6] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

> . . . 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 . . . .*[7]

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."[8] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[9]

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.[10] 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).[11] As a result of these rulemakings, Part C days were

[7] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[8] 69 Fed. Reg. at 49099.
[9] *Id.* (emphasis added).
[10] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[11] *Id*. at 47411.

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."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] 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.[14] In *Allina Health Services v. Price* ("*Allina II*"),[15] 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*.[16] 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.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

*CMS Ruling 1739-R*

On August 17, 2020, in response to the *Allina* decisions, CMS issued Ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The

[12] 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).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] *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.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

Regarding EJRs for this Issue, and the fate of these appeals, the Ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
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> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[22]

[21] *Id*.
[22] CMS Ruling 1739-R at 6-7.

**Providers' Request for EJR**

The Providers point out that the Secretary has not acquiesced to the decisions in *Allina I*[23] and *Allina II*[24] which decided how Medicare Part C Days would be treated in the DSH calculation. The Providers contend that the allegedly uncorrected DSH payment determinations applying the now-vacated rule as though it is still valid not only violates the explicit terms of the *Allina* decisions, but also violates the procedural requirements of the Medicare Act, 42 U.S.C. § 1395hh(a), and the Administrative Procedure Act ("APA"), 5 U.S.C. § 553. The Providers seek corrections of those determinations. In addition to the Part A/SSI fractions published based on this rule, the Providers point out that the Secretary has "left on the books"[25] the vacated 2004 rule itself, which the Board is bound to apply under the provisions of 42 C.F.R. § 405.1867. Thus, the Providers believe the Board has jurisdiction over the appeals but lacks the authority to grant the relief sought by the Providers; consequently, the Board is required to grant EJR.

The Providers maintain that recent developments reinforce the Board's lack of authority to resolve the issue and the need for EJR. The agency's proposed rule to re-adopt the 2004 policy change retroactively, is still only a proposal at this point. If the Agency adopts this proposal as final, which the Providers believe CMS Ruling 1739-R seems to presume would occur in claiming that the pending appeals are now "moot," the payment determinations from which the Providers have appealed would be left undisturbed (and potentially not subject to appeal). The Providers assert that CMS Ruling 1739-R calls for the Board to determine its jurisdiction over Part C appeals, and does not and cannot override the Board's obligation to make determinations as to its authority to decide legal questions. In any event, the Providers assert, the Ruling is invalid as it otherwise violates the clear requirements of the Medicare statute and regulations, which the agency cannot circumvent by issuing a Ruling.

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[26]
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> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the

[23] *Allina Health Servs. v. Sebelius*, 746 F. 3d 1102 (D.C. Cir. 2014) (*Allina I)*.
[24] *Allina Health Servs. v. Price,* 863 F. 3d 937 (D.C. Cir. 2017), aff'd *Azar v. Allina Health Servs.* 139 S. Ct. 1804 (2019) ("*Allina II"*).
[25] Provider's EJR request at 1.
[26] *Id*. at 14.

> Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[27]
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> . . . .
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> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[28]

The Providers also maintain that the Board has jurisdiction over the Providers' challenge to the validity and proper application of CMS Ruling 1739-R as part of the matter at issue. The Providers argue that while the Ruling ordered the Board to remand otherwise jurisdictionally proper appeals of the Part C days issue, is does not by its terms deprive the Board of jurisdiction over the challenges to the actual validity of the ruling. The Providers believe the Board has correct in its decision in *Southwest Consulting 2004 DSH Dual Eligible Days Group et al. v. Blue Cross Blue Shield Association*[29] when it found in the context of analogous CMS Ruling 1498-R,[30] "EJR is appropriate to determine the validity in [the Ruling] that would, if valid, deprive the Board of jurisdiction and thereby prohibit it from granting EJR as to the validity of other substantive provisions [of the Ruling]."[31] Accordingly, the Board was correct when it concluded it has jurisdiction over appeals that challenge the validity of CMS Ruling 1739-R in earlier cases that challenged the validity of Ruling 1798-R.[32]

The Providers contend that because the Secretary has not acquiesced in the decisions of D.C. Circuit and Supreme Court, the Board remains bound by the 2004 DSH rule, and thus, still lacks the authority to grant the relief sought from the determinations applying the 2004 rule. Further, to the extent that the CMS Ruling 1739-R effects whether the Board can adjudicate the

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[27] *Id*. at 14.
[28] *Id.* at 13.
[29] PRRB Dec. 2010-D35 (2010 WL 4214212 (PRRB) (June 14, 2010)).
[30] The Ruling is found on the internet at: https://www.cms.gov/regulations-and-guidance/guidance/rulings/downloads/cms1498r.pdf.
[31] PRRB Dec. 2010-D35 at 5.
[32] *Id. at 13.*

Providers' claims regarding the treatment of Part C days in the Medicare DSH payment adjustment, the issue is properly part of this appeal. Consequently, the Board should also grant EJR over both matters.

**Board's Analysis and Decision**

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP group and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that, as of August 17, 2020, divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after these groups were established).

*Board's Authority*

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Board's analysis is detailed below.

*Jurisdictional Requirements for Providers*

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[33,34]

[33] 42 C.F.R. § 405.1835(a).
[34] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

With respect to the "dissatisfaction" prong of the Board's jurisdiction regulation, for cost report periods ending prior to December 31, 2008, a provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[35] 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.[36]

On August 21, 2008, new regulations governing the Board were effective.[37] 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*").[38] 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.[39]

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 ("CMS 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods that ended on or after December 31, 2008, and began before January 1, 2016, that were pending or filed on or after April 23, 2018.[40] Under this Ruling, if 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) is no longer applicable. However, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.[41]

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[35] 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.).
[36] *Bethesda* at 1258-59.
[37] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[38] 201 F. Supp. 3d 131 (D.D.C. 2016).
[39] *Banner* at 142.
[40] CMS Ruling CMS-1727-R at 1-2.
[41] *Id*. at unnumbered page 7.

The Providers included in the instant EJR request filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2010 and are governed by CMS Ruling CMS-1727-R.[42] The Board further finds that the Providers appeals are permitted under the dictates of CMS-1727-R because they self-disallowed their claims based on the regulation at issue and are challenging the validity of that regulation.

Finally, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000 as required for a group appeal.[43] 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.

*Medicare Part C Days Issue*

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[44] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[45] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[46] To date, CMS has yet to issue its new final rule.[47]

As the Providers' appeals concern the FY 2010 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

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[42] 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.
[43] *See* 42 C.F.R. § 405.1837.
[44] (Emphasis added.)
[45] CMS Ruling 1739-R at 1-2.
[46] Id. at 2.
[47] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[48] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

*Validity of CMS Ruling 1739-R*

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[49]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[50] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is

[48] (Emphasis added.)
[49] EJR Request at 17.
[50] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

> no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[51]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [52] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[53]

As noted prior, the Board must grant EJR 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.[54] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that, as of August 17, 2020, purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

## Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeal (*i.e.*, the appeals are jurisdictionally proper);

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Providers will receive a remand letter of this issue under separate cover; and

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[51] *See Southwest* at 6-7.
[52] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[53] *See* CMS 1739-R at 8.
[54] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

3) The Board hereby **grants** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that, as of August 17, 2020, divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeals.

Board Members Participating:

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Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

5/19/2021

X Clayton J. Nix

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

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

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
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Baltimore, MD 21244
410-786-2671

**Via Electronic Delivery**

Michael Newell
Southwest Consulting Associates
2805 North Dallas Parkway
Plano, TX 75093-8724

RE: ***Expedited Judicial Review Determination***
15-2079GC Southwest Consulting/Carilion Clinic 2011 DSH Medicaid Fraction Part C Days Grp
15-2081GC Southwest Consulting/Carilion Clinic 2011 DSH SSI Fraction Part C Days Group

Dear Mr. Newell:

The above-referenced common issue related party ("CIRP") group appeals[1] includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On April 26, 2021 the Providers in the above-referenced CIRP group appeals filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Request, and then grant it in part and deny it in part, is set forth below.

## Statutory and Regulatory Background

### *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 . . ."

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).

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[2] 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].[3]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[4]

With the creation of Medicare Part C in 1997,[5] 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 years 2001-2004.[6]

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:

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[2] of Health and Human Services.
[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*
[5] 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.
[6] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

> . . . 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 . . . .*[7]

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."[8] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[9]

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.[10] 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).[11] As a result of these rulemakings, Part C days were

[7] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[8] 69 Fed. Reg. at 49099.
[9] *Id.* (emphasis added).
[10] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[11] *Id*. at 47411.

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."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] 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.[14] In *Allina Health Services v. Price* ("*Allina II*")*,*[15] 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*.[16] 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.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

*CMS Ruling 1739-R*

On August 17, 2020, in response to the *Allina* decisions, CMS issued Ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The

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[12] 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).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] *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.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

Regarding EJRs for this Issue, and the fate of these appeals, the Ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[22]

[21] *Id*.
[22] CMS Ruling 1739-R at 6-7.

**Providers' Request for EJR**

The Providers point out that the Secretary has not acquiesced to the decisions in *Allina I*[23] and *Allina II*[24] which decided how Medicare Part C Days would be treated in the DSH calculation. The Providers contend that the allegedly uncorrected DSH payment determinations applying the now-vacated rule as though it is still valid not only violates the explicit terms of the *Allina* decisions, but also violates the procedural requirements of the Medicare Act, 42 U.S.C. § 1395hh(a), and the Administrative Procedure Act ("APA"), 5 U.S.C. § 553. The Providers seek corrections of those determinations. In addition to the Part A/SSI fractions published based on this rule, the Providers point out that the Secretary has "left on the books"[25] the vacated 2004 rule itself, which the Board is bound to apply under the provisions of 42 C.F.R. § 405.1867. Thus, the Providers believe the Board has jurisdiction over the appeals but lacks the authority to grant the relief sought by the Providers; consequently, the Board is required to grant EJR.

The Providers maintain that recent developments reinforce the Board's lack of authority to resolve the issue and the need for EJR. The agency's proposed rule to re-adopt the 2004 policy change retroactively, is still only a proposal at this point. If the Agency adopts this proposal as final, which the Providers believe CMS Ruling 1739-R seems to presume would occur in claiming that the pending appeals are now "moot," the payment determinations from which the Providers have appealed would be left undisturbed (and potentially not subject to appeal). The Providers assert that CMS Ruling 1739-R calls for the Board to determine its jurisdiction over Part C appeals, and does not and cannot override the Board's obligation to make determinations as to its authority to decide legal questions. In any event, the Providers assert, the Ruling is invalid as it otherwise violates the clear requirements of the Medicare statute and regulations, which the agency cannot circumvent by issuing a Ruling.

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[26]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a

[23] *Allina Health Servs. v. Sebelius*, 746 F. 3d 1102 (D.C. Cir. 2014) (*Allina I)*.
[24] *Allina Health Servs. v. Price,* 863 F. 3d 937 (D.C. Cir. 2017), aff'd *Azar v. Allina Health Servs.* 139 S. Ct. 1804 (2019) ("*Allina II"*).
[25] Provider's EJR request at 1.
[26] *Id*. at 14.

> straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[27]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[28]

The Providers also maintain that the Board has jurisdiction over the Providers' challenge to the validity and proper application of CMS Ruling 1739-R as part of the matter at issue. The Providers argue that while the Ruling ordered the Board to remand otherwise jurisdictionally proper appeals of the Part C days issue, is does not by its terms deprive the Board of jurisdiction over the challenges to the actual validity of the Ruling. The Providers believe the Board has correct in its decision in *Southwest Consulting 2004 DSH Dual Eligible Days Group et al. v. Blue Cross Blue Shield Association*[29] when it found in the context of analogous CMS Ruling 1498-R,[30] "EJR is appropriate to determine the validity in [the Ruling] that would, if valid, deprive the Board of jurisdiction and thereby prohibit it from granting EJR as to the validity of other substantive provisions [of the Ruling]."[31] Accordingly, the Board was correct when it concluded it has jurisdiction over appeals that challenge the validity of CMS Ruling 1739-R in earlier cases that challenged the validity of Ruling 1798-R.[32]

The Providers contend that because the Secretary has not acquiesced in the decisions of D.C. Circuit and Supreme Court, the Board remains bound by the 2004 DSH rule, and thus, still lacks the authority to grant the relief sought from the determinations applying the 2004 rule. Further, to the extent that the CMS Ruling 1739-R effects whether the Board can adjudicate the Providers' claims regarding the treatment of Part C days in the Medicare DSH payment adjustment, the issue is properly part of this appeal. Consequently, the Board should also grant EJR over both matters.

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[27] *Id*. at 14.
[28] *Id.* at 13.
[29] PRRB Dec. 2010-D35 (2010 WL 4214212 (PRRB) (June 14, 2010)).
[30] The Ruling is found on the internet at: https://www.cms.gov/regulations-and-guidance/guidance/rulings/downloads/cms1498r.pdf.
[31] PRRB Dec. 2010-D35 at 5.
[32] *Id. at 13.*

## Board's Analysis and Decision

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP group and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that, as of August 17, 2020, divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after these groups were established).

*Board's Authority*

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Board's analysis is detailed below.

*Jurisdictional Requirements for Providers*

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[33,34]

With respect to the "dissatisfaction" prong of the Board's jurisdiction regulation, for cost report periods ending prior to December 31, 2008, a provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a

[33] 42 C.F.R. § 405.1835(a).
[34] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

"self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[35] 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.[36]

On August 21, 2008, new regulations governing the Board were effective.[37] 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*").[38] 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.[39]

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 ("CMS 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods that ended on or after December 31, 2008, and began before January 1, 2016, that were pending or filed on or after April 23, 2018.[40] Under this Ruling, if 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) is no longer applicable. However, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.[41]

The Providers included in the instant EJR request filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2010 and are governed by CMS Ruling CMS-1727-R.[42] The Board further finds that the

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[35] 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.).
[36] *Bethesda* at 1258-59.
[37] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[38] 201 F. Supp. 3d 131 (D.D.C. 2016).
[39] *Banner* at 142.
[40] CMS Ruling CMS-1727-R at 1-2.
[41] *Id*. at unnumbered page 7.
[42] 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

Providers appeals are permitted under the dictates of CMS-1727-R because they self-disallowed their claims based on the regulation at issue and are challenging the validity of that regulation.

Finally, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000 as required for a group appeal.[43] 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.

*Medicare Part C Days Issue*

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[44] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[45] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[46] To date, CMS has yet to issue its new final rule.[47]

As the Providers' appeals concern the FY 2010 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[48] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

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

[43] *See* 42 C.F.R. § 405.1837.

[44] (Emphasis added.)

[45] CMS Ruling 1739-R at 1-2.

[46] Id. at 2.

[47] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).

[48] (Emphasis added.)

*Validity of CMS Ruling 1739-R*

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[49]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[50] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling

[49] EJR Request at 17.

[50] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

> challenged as being contrary to law and which the Board has no authority to invalidate.[51]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [52] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[53]

As noted prior, the Board must grant EJR 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.[54] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that, as of August 17, 2020, purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

## Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeal (*i.e.*, the appeals are jurisdictionally proper);

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Providers will receive a remand letter of this issue under separate cover; and

3) The Board hereby **grants** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that, as of August 17, 2020, divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Review of this determination may be available under the provisions of 42

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[51] *See Southwest* at 6-7.
[52] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[53] *See* CMS 1739-R at 8.
[54] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeals.

Board Members Participating:

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

FOR THE BOARD:

5/19/2021

X Clayton J. Nix

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

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

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Michael Newell
Southwest Consulting Associates
2805 North Dallas Parkway
Plano, TX 75093-8724

RE: ***Expedited Judicial Review Determination***
16-0034GC Southwest Consulting/Carilion Clinic 2012 DSH Medicaid Fraction Part C Days Grp
16-0036GC Southwest Consulting/Carilion Clinic 2012 DSH SSI Fraction Part C Days Group

Dear Mr. Newell:

The above-referenced common issue related party ("CIRP") group appeals[1] includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On April 26, 2021 the Providers in the above-referenced CIRP group appeals filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Request, and then grant it in part and deny it in part, is set forth below.

## Statutory and Regulatory Background

*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 . . ."

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).

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[2] 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].[3]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[4]

With the creation of Medicare Part C in 1997,[5] 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 years 2001-2004.[6]

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:

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[2] of Health and Human Services.
[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*
[5] 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.
[6] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

> . . . 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 . . . .*[7]

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."[8] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[9]

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.[10] 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).[11] As a result of these rulemakings, Part C days were

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[7] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[8] 69 Fed. Reg. at 49099.
[9] *Id.* (emphasis added).
[10] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[11] *Id*. at 47411.

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."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] 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.[14] In *Allina Health Services v. Price* ("*Allina II*")*,*[15] 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*.[16] 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.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

*CMS Ruling 1739-R*

On August 17, 2020, in response to the *Allina* decisions, CMS issued Ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The

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[12] 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).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] *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.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

Regarding EJRs for this Issue, and the fate of these appeals, the Ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[22]

[21] *Id*.
[22] CMS Ruling 1739-R at 6-7.

**Providers' Request for EJR**

The Providers point out that the Secretary has not acquiesced to the decisions in *Allina I*[23] and *Allina II*[24] which decided how Medicare Part C Days would be treated in the DSH calculation. The Providers contend that the allegedly uncorrected DSH payment determinations applying the now-vacated rule as though it is still valid not only violates the explicit terms of the *Allina* decisions, but also violates the procedural requirements of the Medicare Act, 42 U.S.C. § 1395hh(a), and the Administrative Procedure Act ("APA"), 5 U.S.C. § 553. The Providers seek corrections of those determinations. In addition to the Part A/SSI fractions published based on this rule, the Providers point out that the Secretary has "left on the books"[25] the vacated 2004 rule itself, which the Board is bound to apply under the provisions of 42 C.F.R. § 405.1867. Thus, the Providers believe the Board has jurisdiction over the appeals but lacks the authority to grant the relief sought by the Providers; consequently, the Board is required to grant EJR.

The Providers maintain that recent developments reinforce the Board's lack of authority to resolve the issue and the need for EJR. The agency's proposed rule to re-adopt the 2004 policy change retroactively, is still only a proposal at this point. If the Agency adopts this proposal as final, which the Providers believe CMS Ruling 1739-R seems to presume would occur in claiming that the pending appeals are now "moot," the payment determinations from which the Providers have appealed would be left undisturbed (and potentially not subject to appeal). The Providers assert that CMS Ruling 1739-R calls for the Board to determine its jurisdiction over Part C appeals, and does not and cannot override the Board's obligation to make determinations as to its authority to decide legal questions. In any event, the Providers assert, the Ruling is invalid as it otherwise violates the clear requirements of the Medicare statute and regulations, which the agency cannot circumvent by issuing a Ruling.

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[26]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a

[23] *Allina Health Servs. v. Sebelius*, 746 F. 3d 1102 (D.C. Cir. 2014) (*Allina I)*.
[24] *Allina Health Servs. v. Price,* 863 F. 3d 937 (D.C. Cir. 2017), aff'd *Azar v. Allina Health Servs.* 139 S. Ct. 1804 (2019) ("*Allina II"*).
[25] Provider's EJR request at 1.
[26] *Id*. at 14.

> straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[27]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[28]

The Providers also maintain that the Board has jurisdiction over the Providers' challenge to the validity and proper application of CMS Ruling 1739-R as part of the matter at issue. The Providers argue that while the Ruling ordered the Board to remand otherwise jurisdictionally proper appeals of the Part C days issue, is does not by its terms deprive the Board of jurisdiction over the challenges to the actual validity of the Ruling. The Providers believe the Board has correct in its decision in *Southwest Consulting 2004 DSH Dual Eligible Days Group et al. v. Blue Cross Blue Shield Association*[29] when it found in the context of analogous CMS Ruling 1498-R,[30] "EJR is appropriate to determine the validity in [the Ruling] that would, if valid, deprive the Board of jurisdiction and thereby prohibit it from granting EJR as to the validity of other substantive provisions [of the Ruling]."[31] Accordingly, the Board was correct when it concluded it has jurisdiction over appeals that challenge the validity of CMS Ruling 1739-R in earlier cases that challenged the validity of Ruling 1798-R.[32]

The Providers contend that because the Secretary has not acquiesced in the decisions of D.C. Circuit and Supreme Court, the Board remains bound by the 2004 DSH rule, and thus, still lacks the authority to grant the relief sought from the determinations applying the 2004 rule. Further, to the extent that the CMS Ruling 1739-R effects whether the Board can adjudicate the Providers' claims regarding the treatment of Part C days in the Medicare DSH payment adjustment, the issue is properly part of this appeal. Consequently, the Board should also grant EJR over both matters.

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[27] *Id*. at 14.
[28] *Id.* at 13.
[29] PRRB Dec. 2010-D35 (2010 WL 4214212 (PRRB) (June 14, 2010)).
[30] The Ruling is found on the internet at: https://www.cms.gov/regulations-and-guidance/guidance/rulings/downloads/cms1498r.pdf.
[31] PRRB Dec. 2010-D35 at 5.
[32] *Id. at 13.*

**Board's Analysis and Decision**

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP group and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that, as of August 17, 2020, divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after these groups were established).

*Board's Authority*

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Board's analysis is detailed below.

*Jurisdictional Requirements for Providers*

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[33,34]

With respect to the "dissatisfaction" prong of the Board's jurisdiction regulation, for cost report periods ending prior to December 31, 2008, a provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a

[33] 42 C.F.R. § 405.1835(a).
[34] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

"self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[35] 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.[36]

On August 21, 2008, new regulations governing the Board were effective.[37] 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*").[38] 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.[39]

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 ("CMS 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods that ended on or after December 31, 2008, and began before January 1, 2016, that were pending or filed on or after April 23, 2018.[40] Under this Ruling, if 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) is no longer applicable. However, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.[41]

The Providers included in the instant EJR request filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2012 and are governed by CMS Ruling CMS-1727-R.[42] The Board further finds that the

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[35] 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.).
[36] *Bethesda* at 1258-59.
[37] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[38] 201 F. Supp. 3d 131 (D.D.C. 2016).
[39] *Banner* at 142.
[40] CMS Ruling CMS-1727-R at 1-2.
[41] *Id*. at unnumbered page 7.
[42] 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

Providers appeals are permitted under the dictates of CMS-1727-R because they self-disallowed their claims based on the regulation at issue and are challenging the validity of that regulation.

Finally, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000 as required for a group appeal.[43] 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.

*Medicare Part C Days Issue*

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[44] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[45] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[46] To date, CMS has yet to issue its new final rule.[47]

As the Providers' appeals concern the FY 2012 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[48] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

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

[43] *See* 42 C.F.R. § 405.1837.

[44] (Emphasis added.)

[45] CMS Ruling 1739-R at 1-2.

[46] Id. at 2.

[47] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).

[48] (Emphasis added.)

*Validity of CMS Ruling 1739-R*

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[49]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[50] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling

[49] EJR Request at 17.

[50] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

> challenged as being contrary to law and which the Board has no authority to invalidate.[51]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [52] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[53]

As noted prior, the Board must grant EJR 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.[54] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that, as of August 17, 2020, purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

## Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeal (*i.e.*, the appeals are jurisdictionally proper);

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Providers will receive a remand letter of this issue under separate cover; and

3) The Board hereby **grants** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that, as of August 17, 2020, divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Review of this determination may be available under the provisions of 42

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[51] *See Southwest* at 6-7.
[52] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[53] *See* CMS 1739-R at 8.
[54] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeals.

Board Members Participating:

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Gregory H. Ziegler, CPA
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Susan A. Turner, Esq.
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FOR THE BOARD:

5/19/2021

X Clayton J. Nix

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

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

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

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**Via Electronic Delivery**

Michael G. Newell
Southwest Consulting Associates
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Plano, TX 75093-8724

RE: ***Jurisdictional Determination***
SWC St. Elizabeth Post 10/1/2013 DSH Medicaid Fraction Part C Days Group
Case No. 18-1613GC

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Medicare Contractor's ("MAC's") January 6, 2020 jurisdictional challenge in the appeal referenced above. The background of the case, the pertinent facts and the Board's determination are set forth below.

**Background:**

The subject group appeal was filed by Southwest Consulting Associates ("SCA"/"Representative") on September 7, 2018. The group issue statement indicates the group is appealing

> . . . the exclusion of Medicaid-eligible patient days from the numerator of the disproportionate share hospital ("DSH") Medicaid fraction relating to patients who were enrolled in Medicare Advantage plans under Part C of the Medicare Act with respect to discharges occurring on or after October 1, 2013.

The initial participant forming the group was St. Elizabeth Medical Center North (18-0035), which was directly added to the group from a Revised Notice of Program Reimbursement ("RNPR") dated March 14, 2018. On the same date, a Request for Direct Add was filed for St. Elizabeth Fort Thomas (18-0001), also appealing from a RNPR dated March 14, 2018. The group was designated to be complete (fully formed) on September 5, 2019 with these two participants.

In accordance with Board Rule 22, the MAC reviewed the Schedule of Providers and jurisdictional documents and in a letter dated January 2, 2020, it alerted the Board to jurisdictional impediments for the two participants in the group. Subsequently, on January 6, 2020, the MAC filed a formal jurisdictional challenge over the two participants in the group.

**Pertinent Facts:**

***Participant 1: St. Elizabeth Medical Center North (18-0035) 12/31/2013***
Directly Added to Group on September 7, 2018

- Reopening Request dated November 6, 2017
  - Reopening included the following language: The Provider ". . . requests a recalculation of the SSI percentage based on its own fiscal year ending 01/01/2013-12/31/2013. Furthermore, we request a reopening based upon the recalculated SSI percentage."
- Notice of Intent to Reopen dated November 7, 2017
  - The Reopening was issued "To update the SSI% based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 11/06/2017."
- Revised NPR dated March 14, 2018
- Audit Adjustment 1: was made "[t]o update the SSI % and payment factor in accordance with CMS' SSI realignment calculation."

***Participant 2: St. Elizabeth Fort Thomas (18-0001) FYE 12/31/2013***
Directly Added to Group on September 7, 2018

- Reopening Request dated November 6, 2017
  - Reopening included the following language: The Provider ". . . requests a recalculation of the SSI percentage based on its own fiscal year ending 01/01/2013-12/31/2013. Furthermore, we request a reopening based upon the recalculated SSI percentage."
- Notice of Intent to Reopen dated November 7, 2017
  - The Reopening was issued "To update the SSI% based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 11/06/2017."
- Revised NPR dated March 15, 2019
- Audit Adjustment 1: was made "[t]o update the SSI % and payment factor in accordance with CMS' SSI realignment calculation."

**Board Decision**

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

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

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

> issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to contractor determinations), or by the reviewing entity that made the decision. . . .

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

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

42 C.F.R. § 405.1835(a) explains a provider's right to appeal to the Board and specifically references § 405.1889(b):

> (a) *Right to hearing on final contractor determination*. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if—
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under §405.1803. *Exception*: **If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§405.1887(d), **405.1889(b)**, and the ''Exception'' in §405.1873(c)(2)(i)).[1]

As described below, the Board finds that it does not have jurisdiction over the two Providers in this group that appealed from RNPRs because the RNPRs were issued as a result of the Providers' SSI Realignment requests, and did not adjust the DSH Part C Days issue, which is the issue under appeal in this group.

[1] (Bold emphasis added.)

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[2] The reopenings in this case were a result of the Providers' requests to realign their SSI percentages from the Federal Fiscal Year End to their individual cost reporting fiscal year ends. The audit adjustments associated with the RNPRs under appeal clearly revised the SSI percentages in order to realign it from a federal fiscal year to the providers' respective fiscal years. The Notices of Reopening explicitly stated that the purpose of each reopening was issued to use the hospital's fiscal year end to calculate the SSI percentage instead of the federal fiscal year end. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage.

As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

> (2) *First computation: Federal fiscal year*. **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -
>
> (i) Determines the number of patient days that -
>
> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[3]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[4] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at §

[2] 42 C.F.R. § 405.1889(b)(1).
[3] (Emphasis added.)
[4] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).

412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[5]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*. . . .

Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months*** ***included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[6]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g.*, Part C days or Part A days) because that data had been previously gathered on a month-by-month basis and there is no need for CMS to rerun the data matching process in order to effectuate a realignment (*i.e.*, realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

In other words, the determinations were only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPRs were adjustments to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the RNPR appeals of the DSH Part C days issue by St. Elizabeth Medical Center North and St. Elizabeth Fort Thomas. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[7]

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

In conclusion, these two participants are dismissed from the CIRP group as they do not have the right to appeal the RNPRs at issue under 42 C.F.R. § 405.1889 for the DSH Part C days issue. As there are no remaining participants in the CIRP group, the Board hereby closes Case No. 18-1613GC and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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Robert A. Evarts, Esq.
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For the Board:

5/19/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Judith Cummings, CGS Administrators (J-15)

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

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**Via Electronic Delivery**

Michael Newell
Southwest Consulting Associates
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RE: ***Expedited Judicial Review Determination***
16-0179GC Southwest Consulting/Carilion Clinic 2013 DSH Medicaid Fraction Part C Days Grp
16-0181GC Southwest Consulting/Carilion Clinic 2013 DSH SSI Fraction Part C Days Group

Dear Mr. Newell:

The above-referenced common issue related party ("CIRP") group appeals[1] includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On April 26, 2021 the Providers in the above-referenced CIRP group appeals filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Request, and then grant it in part and deny it in part, is set forth below.

## Statutory and Regulatory Background

### *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 . . ."

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).

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[2] 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].[3]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[4]

With the creation of Medicare Part C in 1997,[5] 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 years 2001-2004.[6]

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:

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[2] of Health and Human Services.
[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*
[5] 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.
[6] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

> . . . 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 . . . .*[7]

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."[8] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[9]

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.[10] 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).[11] As a result of these rulemakings, Part C days were

[7] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[8] 69 Fed. Reg. at 49099.
[9] *Id.* (emphasis added).
[10] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[11] *Id*. at 47411.

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."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] 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.[14] In *Allina Health Services v. Price* ("*Allina II*"),[15] 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*.[16] 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.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

*CMS Ruling 1739-R*

On August 17, 2020, in response to the *Allina* decisions, CMS issued Ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The

[12] 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).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] *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.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

Regarding EJRs for this Issue, and the fate of these appeals, the Ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[22]

[21] *Id*.
[22] CMS Ruling 1739-R at 6-7.

**Providers' Request for EJR**

The Providers point out that the Secretary has not acquiesced to the decisions in *Allina I*[23] and *Allina II*[24] which decided how Medicare Part C Days would be treated in the DSH calculation. The Providers contend that the allegedly uncorrected DSH payment determinations applying the now-vacated rule as though it is still valid not only violates the explicit terms of the *Allina* decisions, but also violates the procedural requirements of the Medicare Act, 42 U.S.C. § 1395hh(a), and the Administrative Procedure Act ("APA"), 5 U.S.C. § 553. The Providers seek corrections of those determinations. In addition to the Part A/SSI fractions published based on this rule, the Providers point out that the Secretary has "left on the books"[25] the vacated 2004 rule itself, which the Board is bound to apply under the provisions of 42 C.F.R. § 405.1867. Thus, the Providers believe the Board has jurisdiction over the appeals but lacks the authority to grant the relief sought by the Providers; consequently, the Board is required to grant EJR.

The Providers maintain that recent developments reinforce the Board's lack of authority to resolve the issue and the need for EJR. The agency's proposed rule to re-adopt the 2004 policy change retroactively, is still only a proposal at this point. If the Agency adopts this proposal as final, which the Providers believe CMS Ruling 1739-R seems to presume would occur in claiming that the pending appeals are now "moot," the payment determinations from which the Providers have appealed would be left undisturbed (and potentially not subject to appeal). The Providers assert that CMS Ruling 1739-R calls for the Board to determine its jurisdiction over Part C appeals, and does not and cannot override the Board's obligation to make determinations as to its authority to decide legal questions. In any event, the Providers assert, the Ruling is invalid as it otherwise violates the clear requirements of the Medicare statute and regulations, which the agency cannot circumvent by issuing a Ruling.

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[26]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable

[23] *Allina Health Servs. v. Sebelius*, 746 F. 3d 1102 (D.C. Cir. 2014) (*Allina I)*.
[24] *Allina Health Servs. v. Price,* 863 F. 3d 937 (D.C. Cir. 2017), aff'd *Azar v. Allina Health Servs.* 139 S. Ct. 1804 (2019) ("*Allina II"*).
[25] Provider's EJR request at 1.
[26] *Id*. at 14.

> jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[27]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[28]

The Providers also maintain that the Board has jurisdiction over the Providers' challenge to the validity and proper application of CMS Ruling 1739-R as part of the matter at issue. The Providers argue that while the Ruling ordered the Board to remand otherwise jurisdictionally proper appeals of the Part C days issue, is does not by its terms deprive the Board of jurisdiction over the challenges to the actual validity of the Ruling. The Providers believe the Board has correct in its decision in *Southwest Consulting 2004 DSH Dual Eligible Days Group et al. v. Blue Cross Blue Shield Association*[29] when it found in the context of analogous CMS Ruling 1498-R,[30] "EJR is appropriate to determine the validity in [the Ruling] that would, if valid, deprive the Board of jurisdiction and thereby prohibit it from granting EJR as to the validity of other substantive provisions [of the Ruling]."[31] Accordingly, the Board was correct when it concluded it has jurisdiction over appeals that challenge the validity of CMS Ruling 1739-R in earlier cases that challenged the validity of Ruling 1798-R.[32]

The Providers contend that because the Secretary has not acquiesced in the decisions of D.C. Circuit and Supreme Court, the Board remains bound by the 2004 DSH rule, and thus, still lacks the authority to grant the relief sought from the determinations applying the 2004 rule. Further, to the extent that the CMS Ruling 1739-R effects whether the Board can adjudicate the Providers' claims regarding the treatment of Part C days in the Medicare DSH payment

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[27] *Id*. at 14.
[28] *Id.* at 13.
[29] PRRB Dec. 2010-D35 (2010 WL 4214212 (PRRB) (June 14, 2010)).
[30] The Ruling is found on the internet at: https://www.cms.gov/regulations-and-guidance/guidance/rulings/downloads/cms1498r.pdf.
[31] PRRB Dec. 2010-D35 at 5.
[32] *Id. at 13.*

adjustment, the issue is properly part of this appeal. Consequently, the Board should also grant EJR over both matters.

**Board's Analysis and Decision**

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP group and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that, as of August 17, 2020, divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after these groups were established).

*Board's Authority*

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Board's analysis is detailed below.

*Jurisdictional Requirements for Providers*

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[33,34]

[33] 42 C.F.R. § 405.1835(a).
[34] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

With respect to the "dissatisfaction" prong of the Board's jurisdiction regulation, for cost report periods ending prior to December 31, 2008, a provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[35] 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.[36]

On August 21, 2008, new regulations governing the Board were effective.[37] 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*").[38] 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.[39]

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 ("CMS 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods that ended on or after December 31, 2008, and began before January 1, 2016, that were pending or filed on or after April 23, 2018.[40] Under this Ruling, if 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) is no longer applicable. However, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.[41]

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[35] 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.).
[36] *Bethesda* at 1258-59.
[37] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[38] 201 F. Supp. 3d 131 (D.D.C. 2016).
[39] *Banner* at 142.
[40] CMS Ruling CMS-1727-R at 1-2.
[41] *Id*. at unnumbered page 7.

The Providers included in the instant EJR request filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2013 and are governed by CMS Ruling CMS-1727-R.[42] The Board further finds that the Providers appeals are permitted under the dictates of CMS-1727-R because they self-disallowed their claims based on the regulation at issue and are challenging the validity of that regulation.

Finally, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000 as required for a group appeal.[43] 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.

*Medicare Part C Days Issue*

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[44] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[45] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[46] To date, CMS has yet to issue its new final rule.[47]

As the Providers' appeals concern the FY 2013 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

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[42] 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.
[43] *See* 42 C.F.R. § 405.1837.
[44] (Emphasis added.)
[45] CMS Ruling 1739-R at 1-2.
[46] Id. at 2.
[47] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[48] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

*Validity of CMS Ruling 1739-R*

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[49]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[50] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is

[48] (Emphasis added.)
[49] EJR Request at 17.
[50] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

> no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[51]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [52] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[53]

As noted prior, the Board must grant EJR 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.[54] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that, as of August 17, 2020, purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

## Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeal (*i.e.*, the appeals are jurisdictionally proper);

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Providers will receive a remand letter of this issue under separate cover; and

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[51] *See Southwest* at 6-7.
[52] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[53] *See* CMS 1739-R at 8.
[54] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

3) The Board hereby **grants** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that, as of August 17, 2020, divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeals.

Board Members Participating:

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Kevin D. Smith, CPA

FOR THE BOARD:

5/20/2021

X Clayton J. Nix

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

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

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
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410-786-2671

**Via Electronic Delivery**

Barry Cockrell, Esq.
Baker, Donelson, Bearman, Caldwell & Berkowitz
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RE: ***Expedited Judicial Review Determination***
Forest County General Hospital (Prov. No. 25-0078)
FYEs 09/30/13, 09/30/12, 09/30/11
Case Nos. 17-0336, 16-2069, 15-2519

Dear Mr. Cockrell:

The above referenced appeals includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On April 30, 2021 the Providers in the above-referenced appeals filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Request, and then grant it in part and deny it in part, is set forth below.

## Statutory and Regulatory Background

### *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[1] 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].[2]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[3]

With the creation of Medicare Part C in 1997,[4] 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 years 2001-2004.[5]

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:

> [o]nce 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*

[1] of Health and Human Services.
[2] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[3] *Id.*
[4] 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.
[5] 69 Fed. Reg. 48915, 49099 (Aug. 11, 2004).

> *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.*[6]

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."[7] In response to a comment regarding this change, the Secretary explained that:

> *[W]e do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction.*
>
> *Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction*. . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[8]

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.[9] 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).[10] 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,

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[6] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[7] 69 Fed. Reg. at 49099.
[8] *Id.* (emphasis added).
[9] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[10] *Id*. at 47411.

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."[11]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[12] 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.[13] In *Allina Health Services v. Price* ("*Allina II*")*,*[14] 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*.[15] 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.[16] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[17]

*CMS Ruling 1739-R*

On August 17, 2020, in response to the *Allina* decisions, CMS issued Ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[18] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[19] The Ruling explains

[11] 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).
[12] 746 F. 3d 1102 (D.C. Cir. 2014).
[13] *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.").
[14] 863 F.3d 937 (D.C. Cir. 2017).
[15] *Id.* at 943.
[16] Id. at 943-945.
[17] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[18] CMS Ruling 1739-R (Aug. 17, 2020).
[19] *Id*.

that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[20]

Regarding EJRs for this Issue, and the fate of these appeals, the ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[21]

[20] *Id*.
[21] CMS Ruling 1739-R at 6-7.

**Provider's Request for EJR**

The Provider maintains the Secretary has continued to apply a policy of including Part C inpatient days in the Medicare Part A/SSI fraction and excluding such days from the Medicaid fraction, even though such policy has been vacated and deemed invalid by the United States District Court for the District of Columbia, the United States Court of Appeals for the District of Columbia Circuit, and the United States Supreme Court. *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) ("*Allina I*"); *Allina Health Servs. v. Price*, 863 F.3d 937 (D.C. Cir. 2017) ("*Allina II*"); *Azar v. Allina Health* Services, 139 S.Ct. 1804, 1816 (2019) ("*Allina III*"). The Provider contends the Secretary has not acquiesced in those decisions. Instead, the Secretary unlawfully has continued to apply the Part C Days policy adopted in the now-vacated 2004 Rule including in the Secretary's payment determinations at issue for the Providers. The Providers assert also at issue is CMS Ruling 1739-R which purports to divest the Board of its jurisdictional authority over the appeals and unlawfully divests the Providers of their statutory right to appeal pursuant to 42 U.S.C. 1395oo(a).[22] The Provider argues the Board should grant EJR because the Board has jurisdiction over the appeals and the Board lacks the authority to strike down the 2004 Rule and enforce the rulings in *Allina I, Allina II, and Allina III* and to invalidate CMS Ruling 1739-R and entertain jurisdiction over the appeals.[23]

The Provider contends that the 2004 Rule is unlawful as it is contrary to 42 U.S.C. § 1395ww(d)(5)(F)(vi) and was promulgated in violation of the Medicare statute and Administrative Procedure Act ("APA"), as determined under *Allina I, Allina II, and Allina III*. The Provider maintains that CMS' regulation at 42 C.F.R. § 405.1867 states that the Board must comply with all provisions of Title XVIII of the Act and regulations issued thereunder. The Provider asserts the Secretary has not acquiesced in the decision in *Allina I, Allina II, or Allina III* therefore, the Board remains bound by the terms of the 2004 Rule on the treatment of Part C days in the DSH payment calculation. The Provider argues as a result, the Board lacks the authority to decide the validity of the Part C policy that was applied in the payment determinations at issue, because a decision in the Provider's favor would be contrary to the 2004 Rule and thus, exceed the Board's authority established by 42 C.F.R. § 405.1867.[24] The Providers also contend that CMS Ruling 1739-R is unlawful as it is contrary to 42 U.S.C. §§ 1395hh(a) and 1395oo(a).[25] The Provider assert the publication of 1739-R violates 42 U.S.C. § 1395hh(a) as it establishes a procedural policy that controls payments to the hospitals, without providing for the requisite notice-and-comment rulemaking. The Provider argues the Ruling contravenes Congress' grant of jurisdiction to the Board and the Providers' right to appeal to the Board under 42 U.S.C. § 1395oo(a).[26] The Provider maintains CMS' regulations state that the Board must comply with agency rulings. As a result, the Board lacks the authority to decide the validity of CMS Ruling 1739-R, therefore, EJR is appropriate. The Provider requests that the

[22] Providers' April 30, 2021 Petition for Expedited Judicial Review at 2.
[23] *Id*. at 13.
[24] *Id.* at 14.
[25] *Id.* at 15.
[26] *Id.* at 9.

Board grant EJR as to the Provider's appeals of the DSH Medicare Part C Days issue in the above referenced appeals.[27]

**Board's Analysis and Decision**

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is the Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage. The first issue is the ***substantive issue*** and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that, as of August 17, 2020, divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020.

*Board's Authority*

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) 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.

*Jurisdictional Requirements for Providers*

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[28,29]

With respect to the "dissatisfaction" prong of the Board's jurisdiction regulation, for cost report periods ending prior to December 31, 2008, a provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a

[27] *Id.* at 15.
[28] 42 C.F.R. § 405.1835(a).
[29] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

"self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[30] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[31]

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

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R ("CMS 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods that ended on or after December 31, 2008, and began before January 1, 2016, that were pending or filed on or after April 23, 2018.[35] Under this Ruling, if 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) is no longer applicable. However, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.[36]

The Board finds that the above referenced Provider filed appeals from original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2011, 2012 and 2013 and are governed by CMS Ruling CMS-1727-R.[37] The

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[30] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[31] *Bethesda* at 1258-59.
[32] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[33] 201 F. Supp. 3d 131 (D.D.C. 2016).
[34] *Banner* at 142.
[35] CMS Ruling CMS-1727-R at 1-2.
[36] *Id*. at unnumbered page 7.
[37] 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

Board further finds that the Provider's appeals are permitted under the dictates of CMS-1727-R because they self-disallowed their claims based on the regulation at issue and are challenging the validity of that regulation.

Finally, the Provider's documentation shows that the estimated amount in controversy exceeds $10,000 for each appeal as required for each of the individual appeals[38] and that the appeals were timely filed. Based on the above, the Board concludes that it has jurisdiction for the above-captioned appeals and the underlying Provider. The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount in each case.

*Medicare Part C Days Issue*

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[39] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[40] *i.e*., the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[41] To date, CMS has yet to issue its new final rule.[42]

The Board finds as the Provider's appeals concern FYEs 09/30/11, 09/30/12, and 09/30/13 cost reporting periods, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e*., the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny the Provider's EJR requests concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[43]Accordingly, the Board will issue, under separate cover, a remand for the Provider's "qualifying" appeals determined to be "jurisdictionally proper" (*i.e*., determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

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

[38] *See* 42 C.F.R. § 405.1835(a).

[39] (Emphasis added.)

[40] CMS Ruling 1739-R at 1-2.

[41] Id. at 2.

[42] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).

[43] (Emphasis added.)

*Validity of CMS Ruling 1739-R*

Within the EJR Request, the Provider also challenges the validity of CMS Ruling 1739-R, stating:

> The publication of 1739-R violates 42 U.S.C. 1395hh(a), as it establishes a procedural policy that controls payments to the hospitals, without providing for the requisite notice-and-comment rulemaking. The Ruling further contravenes Congress' grant of jurisdiction to the Board and the Providers' right to appeal to the Board under 42 U.S.C. § 1395oo(a).[44]
> . . . .
> . . . The Ruling provides no means for providers that had properly pending Board appeals that are remanded to MACs to pursue their appeal rights under 42 U.S.C. § 1395oo. Pursuant to 1739-R there will be no reopenings and thus no revised determinations. And even if revised determinations were permitted, no revision to reimbursement that is necessary to permit an appeal to the Board and ultimately to the courts is anticipated.
>
> The Ruling, which is "binding" and affects hospitals' substantive Medicare payment and appeal rights was not adopted through notice-and comment rulemaking and is therefore unlawful.[45]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[46] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the

[44] Providers' April 30, 2021 Petition for Expedited Judicial Review at 9.
[45] *Id.* at 10.
[46] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

> Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[47]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [48] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[49]

As noted prior, the Board must grant EJR 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.[50] Here, the Provider essentially challenges the Board's *application* of CMS Ruling 1739-R. Specifically, the Provider challenges the validity of the mandate within the Ruling that, as of August 17, 2020, purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board concludes that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

**Conclusion**

1) The Board concludes it has jurisdiction to hear the appeals of the provider within the instant appeals (*i.e.*, the appeals are jurisdictionally proper);

2) The Board hereby **denies** Provider's EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Provider will receive a remand letter of this issue for the various fiscal years under separate cover; and

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[47] *See Southwest* at 6-7.
[48] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[49] *See* CMS 1739-R at 8.
[50] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

3) The Board hereby **grants** EJR for the Provider for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that, as of August 17, 2020, divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeals.

Board Members Participating:

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

FOR THE BOARD:

5/25/2021

X Clayton J. Nix

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

cc: Bill Tisdale, Novitas Solutions, Inc.
Wilson Leong, FSS

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Leslie Goldsmith, Esq.
Baker, Donelson, Bearman, Caldwell & Berkowitz
100 Light Street
Baltimore, MD 21042

RE: ***Expedited Judicial Review Determination***
Raritan Bay Medical Center Perth Amboy Division (Prov. No. 31-0039)
FYE 12/31/10
Case No. 21-0002

Dear Ms. Goldsmith:

The above-referenced appeal includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On April 30, 2021 the Provider in the above-referenced appeal filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Provider's EJR Request, and then grant it in part and deny it in part, is set forth below.

## Statutory and Regulatory Background

*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[1] 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].[2]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[3]

With the creation of Medicare Part C in 1997,[4] 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 years 2001-2004.[5]

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:

> [o]nce a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A.

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[1] of Health and Human Services.
[2] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[3] *Id.*
[4] 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.
[5] 69 Fed. Reg. 48915, 49099 (Aug. 11, 2004).

> *. . . 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.*[6]

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."[7] In response to a comment regarding this change, the Secretary explained that:

> *[W]e do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction.*
>
> *Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction*. . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[8]

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.[9] 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).[10] As a result of these rulemakings, Part C days were

[6] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[7] 69 Fed. Reg. at 49099.
[8] *Id.* (emphasis added).
[9] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[10] *Id*. at 47411.

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."[11]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[12] 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.[13] In *Allina Health Services v. Price* ("*Allina II*"),[14] 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*.[15] 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.[16] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[17]

*CMS Ruling 1739-R*

On August 17, 2020, in response to the *Allina* decisions, CMS issued Ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[18] Further, the Ruling requires that the Board remand any otherwise jurisdictionally

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[11] 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).
[12] 746 F. 3d 1102 (D.C. Cir. 2014).
[13] *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.").
[14] 863 F.3d 937 (D.C. Cir. 2017).
[15] *Id.* at 943.
[16] Id. at 943-945.
[17] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[18] CMS Ruling 1739-R (Aug. 17, 2020).

proper challenge raising this issue to the appropriate Medicare contractor.[19] The Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[20]
Regarding EJRs for this Issue, and the fate of these appeals, the ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[21]

[19] *Id*.
[20] *Id*.
[21] CMS Ruling 1739-R at 6-7.

**Provider's Request for EJR**

The Provider maintains the Secretary has continued to apply a policy of including Part C inpatient days in the Medicare Part A/SSI fraction and excluding such days from the Medicaid fraction, even though such policy has been vacated and deemed invalid by the United States District Court for the District of Columbia, the United States Court of Appeals for the District of Columbia Circuit, and the United States Supreme Court. *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) ("*Allina I*"); *Allina Health Servs. v. Price*, 863 F.3d 937 (D.C. Cir. 2017) ("*Allina II*"); *Azar v. Allina Health* Services, 139 S.Ct. 1804, 1816 (2019) ("*Allina III*"). The Provider contends the Secretary has not acquiesced in those decisions. Instead, the Secretary unlawfully has continued to apply the Part C Days policy adopted in the now-vacated 2004 Rule including in the Secretary's payment determinations at issue for the Provider. The Provider asserts also at issue is CMS Ruling 1739-R which purports to divest the Board of its jurisdictional authority over the appeals and unlawfully divests the Provider of its statutory right to appeal pursuant to 42 U.S.C. 1395oo(a).[22] The Provider argues the Board should grant EJR because the Board has jurisdiction over the appeals and the Board lacks the authority to strike down the 2004 Rule and enforce the rulings in *Allina I, Allina II, and Allina III* and to invalidate CMS Ruling 1739-R and entertain jurisdiction over the appeals.[23]

The Provider contends that the 2004 Rule is unlawful as it is contrary to 42 U.S.C. § 1395ww(d)(5)(F)(vi) and was promulgated in violation of the Medicare statute and Administrative Procedure Act ("APA"), as determined under *Allina I, Allina II, and Allina III*. The Provider maintains CMS' regulation at 42 C.F.R. § 405.1867 states that the Board must comply with all provisions of Title XVIII of the Act and regulations issued thereunder. The Provider asserts the Secretary has not acquiesced in the decision in *Allina I, Allina II, or Allina III* therefore, the Board remains bound by the terms of the 2004 Rule on the treatment of Part C days in the DSH payment calculation. The Provider argues as a result, the Board lacks the authority to decide the validity of the Part C policy that was applied in the payment determinations at issue, because a decision in the Provider's favor would be contrary to the 2004 Rule and thus, exceed the Board's authority established by 42 C.F.R. § 405.1867.[24] The Provider also contends that CMS Ruling 1739-R is unlawful as it is contrary to 42 U.S.C. §§ 1395hh(a) and 1395oo(a).[25] The Provider asserts the publication of 1739-R violates 42 U.S.C. 1395hh(a) as it establishes a procedural policy that controls payments to the hospitals, without providing for the requisite notice-and-comment rulemaking. The Provider argues the Ruling contravenes Congress' grant of jurisdiction to the Board and the Provider's right to appeal to the Board under 42 U.S.C. § 1395oo(a).[26] The Provider maintains CMS' regulations state that the Board must comply with agency rulings. As a result, the Board lacks the authority to decide the validity of CMS Ruling 1739-R, therefore, EJR is appropriate. The Provider requests that the Board grant

[22] Provider's April 30, 2021 Petition for Expedited Judicial Review at 2.
[23] *Id*. at 13.
[24] *Id.* at 14.
[25] *Id.* at 15.
[26] *Id.* at 9.

EJR as to the Provider's appeal of the DSH Medicare Part C Days issue in the above referenced appeal.[27]

**Board's Analysis and Decision**

After review of the Provider's EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.
The first issue is the Provider's challenge to the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage. The first issue is the ***substantive issue*** and the source of the Provider's dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that, as of August 17, 2020, divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020.

*Board's Authority*

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) 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.

*Jurisdictional Requirements for Providers*

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for the Provider requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[28,29]

With respect to the "dissatisfaction" prong of the Board's jurisdiction regulation, for cost report periods ending prior to December 31, 2008, a provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital*

[27] *Id.* at 15.
[28] 42 C.F.R. § 405.1835(a).
[29] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

*Association v. Bowen*.[30] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[31] On August 21, 2008, new regulations governing the Board were effective.[32] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[33] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[34]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R ("CMS 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods that ended on or after December 31, 2008, and began before January 1, 2016, that were pending or filed on or after April 23, 2018.[35] Under this Ruling, if 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) is no longer applicable. However, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.[36]

The Board finds that the above referenced Provider filed its appeal from an original Notice of Program Reimbursement ("NPRs") in which the Medicare contractor settled its cost reporting period ending in 2010 and is governed by CMS Ruling CMS-1727-R.[37] The Board further finds

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[30] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[31] *Bethesda* at 1258-59.
[32] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[33] 201 F. Supp. 3d 131 (D.D.C. 2016).
[34] *Banner* at 142.
[35] CMS Ruling CMS-1727-R at 1-2.
[36] *Id*. at unnumbered page 7.
[37] 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.

that the Provider's appeal is permitted under the dictates of CMS-1727-R because it self-disallowed its claims based on the regulation at issue and is challenging the validity of that regulation.

Finally, the Provider's documentation shows that the estimated amount in controversy exceeds $10,000 as required for individual appeals.[38] The appeal was timely filed. Based on the above, the Board concludes 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.

*Medicare Part C Days Issue*

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[39] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[40] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[41] To date, CMS has yet to issue its new final rule.[42]

The Board finds as the Provider's appeal concerns the FYE 12/31/10 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the provider's Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny the Provider's EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[43]Accordingly, the Board will issue, under separate cover, a remand for the provider with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

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[38] *See* 42 C.F.R. § 405.1835(a).
[39] (Emphasis added.)
[40] CMS Ruling 1739-R at 1-2.
[41] Id. at 2.
[42] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[43] (Emphasis added.)

*Validity of CMS Ruling 1739-R*

Within the EJR Request, the Provider also challenges the validity of CMS Ruling 1739-R, stating:

> The publication of 1739-R violates 42 U.S.C. 1395hh(a), as it establishes a procedural policy that controls payments to the hospitals, without providing for the requisite notice-and-comment rulemaking. The Ruling further contravenes Congress' grant of jurisdiction to the Board and the Providers' right to appeal to the Board under 42 U.S.C. § 1395oo(a).[44]
> . . . .
> . . . The Ruling provides no means for providers that had properly pending Board appeals that are remanded to MACs to pursue their appeal rights under 42 U.S.C. § 1395oo. Pursuant to 1739-R there will be no reopenings and thus no revised determinations. And even if revised determinations were permitted, no revision to reimbursement that is necessary to permit an appeal to the Board and ultimately to the courts is anticipated.
>
> The Ruling, which is "binding" and affects hospitals' substantive Medicare payment and appeal rights was not adopted through notice-and comment rulemaking and is therefore unlawful.[45]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[46] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for

[44] Provider's April 30, 2021 Petition for Expedited Judicial Review at 9.
[45] *Id.* at 10.
[46] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

> the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[47]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration"[48] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[49]

As noted prior, the Board must grant EJR 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.[50] Here, the Provider is essentially challenging the Board's *application* of CMS Ruling 1739-R. Specifically, the Provider is challenging the validity of the mandate within the Ruling that, as of August 17, 2020, purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board concludes that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

**Conclusion**

1) The Board concludes it has jurisdiction to hear the appeal of the provider within the instant appeal (*i.e.*, the appeal is jurisdictionally proper);

2) The Board hereby **denies** Provider's EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Provider will receive a remand letter of this issue under separate cover; and

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[47] *See Southwest* at 6-7.
[48] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[49] *See* CMS 1739-R at 8.
[50] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

3) The Board hereby **grants** EJR for the Provider for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that, as of August 17, 2020, divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:

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

FOR THE BOARD:

5/26/2021

X Clayton J. Nix

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

cc: Bruce Snyder, Novitas Solutions, Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

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RE: ***EJR Determination***
19-2083G Powers Pyles 2016 GME Solutions DGME Fellowship Penalty Group
20-1605G Powers Pyles 2018 Incorrect DGME Cap & Weighting for Residents Beyond IRP Grp
20-1919G Powers Pyles 2017 Incorrect DGME Cap & Weighting for Residents Beyond IRP Grp
21-1135G Powers Pyles 2019 Incorrect DGME Cap & Weighting for Residents Beyond IRP Grp

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 29, 2020 request for expedited judicial review ("EJR"). The decision of the Board is set forth below.

**Issue in Dispute:**

The issue for which EJR is requested is:

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

**Background:**

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

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

1. The hospital's number of FTE residents, or "FTE count;"

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

2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and

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

These appeals concern the first component of the DGME payment calculation—the resident FTE count.

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

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

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

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

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**The Providers' Position:**

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

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

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

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

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

Third, in some situations, as demonstrated by the Table on page 13 of the Providers' EJR request, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Providers point out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.

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

**Decision of the Board:**

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

***A. Board Review of Compliance with the Reimbursement Requirement of an Appropriate Cost Report Claim Pursuant to 42 C.F.R. § 405.1873***

A number of Providers appealed from final determinations and/or the untimely issuance of a final determination covering cost reporting periods beginning on or after January 1, 2016, and are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[25] All of the Providers in Case Nos. 20-1919G, 20-1605G, and 21-1135G, as well as four Providers in Case No. 19-2083G have appealed from final determinations and/or the untimely issuance of a final determination for cost reporting periods beginning on or after January 1, 2016. The four Providers from Case No. 19-2083G are:

- Prov. No. 26-0032, Barnes Jewish Hospital (12/31/2016)
- Prov. No. 33-0270, Hospital for Special Surgery (12/31/2016)
- Prov. No. 31-0019, St. Joseph's Regional Medical Center (12/31/2016)
- Prov. No. 44-0049, Methodist Healthcare Memphis Hospitals (12/31/2016)

Specifically, effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[26]

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[25] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").

[26] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[27] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[28] As no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[29] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made.[30] As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

### *B. Jurisdiction*

#### *1. Jurisdiction of Providers appealing NPRs Beginning **Prior to** January 1, 2016*

Five Providers in Case No. 19-2083G have appealed from cost reporting periods beginning prior to January 1, 2016:

- 26-0141, University of Missouri (6/30/2016)
- 45-0068, Memorial Hermann Texas Medical Center (6/30/2016)
- 39-0256, Penn State Health Milton S. Hershey Medical Center (6/30/2016)
- 26-0048, Truman Medical Center Hospital Hill (6/30/2016)
- 23-0046, University of Michigan Hospitals & Health Centers (6/30/2016)

[27] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[28] *See* 42 C.F.R. § 405.1873(a).
[29] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[30] Although no question was raised in this appeal regarding whether an appropriate claim was made, the Board recognizes that the Providers' cost reports affected by these regulations included a claim for the disputed DGME payment as a protested amount in their as-filed cost reports as evidenced by Tab D of the jurisdictional documents for each Provider which accompanied the Schedules of Providers. The Providers each included a summary of their Protested amounts which included the DGME calculation and a copy of Worksheet E, Part A which demonstrated the Providers claimed a protested amount and/or had an adjustment to protested amounts that reflected a challenge to the DGME cap.

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

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

The Secretary did not appeal the decision in *Banner* and decided to 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.

Based on its review of the record, the Board finds that each of the above Providers who filed from NPRs beginning prior to January 1, 2016 filed timely and proper appeals. In this regard, the Board finds that the above Providers are governed by CMS Ruling CMS-1727-R and that the above Providers' appeal are permitted under the dictates of CMS-1727-R because they self-

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

disallowed their claims based on the regulation at issue and are challenging the validity of that regulation.

*2. Jurisdiction of Providers appealing Cost Reporting Periods Beginning **On or After** January 1, 2016*

The remaining Providers are appealing from cost reporting periods beginning ***on or after*** January 1, 2016 based on either an NPR or the Medicare Contractor's failure to issue a timely final determination under the provisions of 42 C.F.R. § 405.1835(c).[36] The Board notes that the November 13, 2015 OPPS Final Rule eliminated the jurisdictional requirement of an appropriate cost report claim in existing §§ 405.1835(a)(1) and 405.1840(b)(3) for Board appeals of cost reporting periods beginning on or after January 1, 2016.[37] Based on its review of the record, the Board finds that each of these Providers filed timely and proper appeals.

*3. Jurisdiction over the groups*

The participants' documentation in all of the EJR requests shows that the estimated amount in controversy exceeds $50,000 in each group, as required for a group appeal.[38] 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.

### *C. Board's Analysis of the Appealed Issue*

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

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}$$ [39]

[36] The Provider appealing from the nonissuance of an NPR are:
1. In Case No. 19-2083G—Methodist Healthcare Memphis Hospitals (Prov. No. 44-0049, FYE 12/31/2016);
2. In Case No. 21-1135G—University of Michigan Hospitals & Health Centers (Prov. No. 23-0046, FYE 6/30/2019); Memorial Hermann Texas Medical Center (Prov. No. 45-0068, FYE 6/30/2019);
3. In Case No. 20-1065—University of Michigan Hospitals & Health Centers (Prov. No. Prov. No. 23-0046, FYE 6/30/2018); Memorial Hermann Texas Medical Center (Prov. No. 45-0068, FYE 6/30/2018); Hospital for Special Surgery (Prov. No. 33-0270, FYE 12/31/2018); University of Missouri Health Care (Prov. No. 26-0141, FYE 6/30/2018); and
4. In Case No. 20-1919G—Methodist Healthcare Memphis Hospitals (Prov. No. 44-0049, FYE 12/31/2017).

[37] 80 Fed. Reg. 70298 (Nov. 13, 2015).

[38] *See* 42 C.F.R. § 405.1837.

[39] EJR Request at 4.

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[40] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[41] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[42]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[43] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We

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

[41] 66 Fed. Reg. at 39894 (emphasis added).

[42] (Emphasis added.)

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

believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[44] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[45] (*i.e.*, ratios) using variables a, b, c, and d:

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

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[46]

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

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

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

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

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

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

[46] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

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

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

### *D. Board's Decision Regarding the EJR Request*

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests 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 the cases. The Board's jurisdictional determinations are subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877.

Board Members Participating:

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Susan A. Turner, Esq.
Kevin D. Smith, CPA

For the Board:

5/28/2021

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS
Wilson Leong, FSS