DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

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**RE:** ***EJR Determination***
10-0924GC QRS WFHC 2005, 2007 DSH Medicare Managed Care Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 13, 2019 request for expedited judicial review ("EJR")[1] for the appeal referenced above, as well as the Medicare Contractor's July 2, 2019 and Providers' July 8, 2019 response to the Board's June 6, 2019 request for additional information. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this appeal is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.[2]

**Statutory and Regulatory Background: Medicare DSH Payment**

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

[1] This request for EJR included nine other cases for which an EJR decision was issued on May 31, 2019.
[2] Providers' EJR request at 1.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*

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

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

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

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

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

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

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

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

> *part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[12]

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

> is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[21]

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

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

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

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

Medicare fractions published for FY 2012.[29] Once again, the Secretary has not acquiesced to this decision.

**Providers' Request for EJR**

The Providers explain that "[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The '2004 Rule') The Board is bound by the 2004 rule."[30] Accordingly, the Providers contend that the Board should grant their request for EJR.

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

**Decision of the Board**

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

Jurisdiction

The two (2) participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2005 and 2007.

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

[29] *Id.* at 943-945.
[30] Providers' EJR Request at 1.
[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.).

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.

A. ***Improper*** *Inclusion of Provider Which Attempted to Transfer Part C Days Issue After its Individual Case was Closed*

The Board notes that the Schedules of Providers submitted in Case No. 10-0924GC on May 10, 2019, improperly includes Provider #1, Covenant Medical Center's (Provider No. 16-0067, FYE June 30, 2005). Provider #1 filed a hearing request to which the Board assigned Case No. 08-1716. However, the group representative failed to include Provider #1's original hearing request under Tab B of the Schedule of Providers as required by Board 21.3.2.[36] Rather, the group representative only included Provider #1's alleged request dated October 13, 2008 to add

[32] *Bethesda*, 108 S. Ct. at 1258-59.
[33] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[34] 201 F. Supp. 3d 131 (D.D.C. 2016).
[35] *Id.* at 142.
[36] The Board's Rules can be found on the internet at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.html.

the Part C Days issue to its individual appeal which includes the following *detailed* description and estimated reimbursement impact:

> Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, the Medicaid days proxy, set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Provider contents that the Intermediary failed to include patient days applicable to Medicare Managed Care Part C patients who were also eligible for Medicaid in the Medicaid fraction for Medicare DHS payment adjustment calculation purposes. . . .
>
> Estimated Reimbursement Amount: $56,483. . . .[37]

Further, under Tab G, the group representative included Provider #1's August 20, 2011 request to transfer the Part C Days issue from Case No. 08-1716 to the current case, *i.e.*, Case No. 10-0924GC.

At the outset, the Board notes that it has no record of having received the alleged October 13, 2008 request to add the issue to Case No. 08-1716. Further, the copy included by behind Tab B for Provider #1 in the Schedule of Providers does not include any certification ***or*** proof of delivery *to the Board* (rather it only includes proof of delivery to WPS dated October 16, 2008). Further, the group representative did not attach the October 13, 2008 request to add issues to the August 20, 2011 transfer request.

Notwithstanding, the Board's docket for Case No. 08-1716 does confirm that, on July 22, 2008, the Provider *withdrew* its request for hearing and that, consistent with that withdrawal, the Board closed Case No. 08-1716 on August 1, 2008. Significantly, the Provider's withdrawal and the Board's closure occurred *several months prior to* the alleged October 13, 2008 request to add the issue, and *more than three years prior to* the August 20, 2011 transfer request.

The Board finds that it lacks jurisdiction over the appeal of Provider #1, Covenant Medical Center's (Provider No. 16-0067, FYE June 30, 2005) because Provider #1 did not both add *and* transfer the Part C issue to Case No. 10-0924GC prior to the Board's closure of its individual appeal. Specifically, the Board finds that Provider #1 did not have a valid appeal of the Part C issue since the appeal had already been closed when Provider #1 allegedly attempted to add the Part C issue and that, therefore, any subsequent attempt to transfer that issue would necessarily be void and invalid. Accordingly, the Board hereby dismisses Provider #1, Covenant Medical Center (Provider No. 16-0067, FYE June 30, 2005) from Case No. 10-0924GC as it has no valid

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[37] *See* Provider #1's Request to Add Issues (dated Oct. 13, 2008) at Tab 1 (a copy is included in the Schedule of Providers behind Tab B for Provider #1 where Tab 1 is the statement of the issues but *it is an* ***incomplete*** *copy* as Tabs 2 and 3 are missing).

appeal. Since jurisdiction over a provider through a valid appeal is a prerequisite to granting EJR, the Board hereby denies Provider #1's request for EJR.[38]

*B. Jurisdiction Over A Provider Which Did Not Appeal the Part C Days Issue*

Provider #2, Covenant Medical Center (Provider No. 16-0067, FYE 6/30/2007) filed its original hearing request on September 1, 2009 and the Board was assigned Case No. 09-2200 to that appeal. The record for Provider #2 does *not* contain a request to add issues. As set forth below, the Board finds that it does not have jurisdiction over the Part C days issue because the Provider did not appeal this issue or timely add that issue to its appeal.

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

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

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

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

> **Rule 7 - Issue Statement and Claim of Dissatisfaction**
>
> For each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction. (*See*

[38] *See* 42 C.F.R. § 405.1842(a).

*Rule 8 for special instructions regarding multi-component disputes*.)

**7.1 - NPR or Revised NPR Adjustments**

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

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

**B. No Access to Data**: If the Provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

**7.2 - Self-Disallowed Items**

**A. Authority Requires Disallowance**

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

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

**B. No Access to Data**

If the Provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

**C. Protest**

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

**Rule 8 - Framing Issues for Adjustments Involving Multiple Components**

**8.1 – General**

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

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

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

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

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

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

You will receive an acknowledgement from the Board indicating that your appeal request has been received and the case number assigned. *If your appeal request does not comply with the filing requirements, the Board **may dismiss** your appeal* or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.[39]

Specifically, Provider #2's hearing request included the following issues:

1. Availability of MEDPAR and SSA records to reconcile the SSI data maintained by CMS
2. Paid Days vs. Eligible Days in the SSI fraction (*Legacy Emanuel* issues[40])

[39] (Italics and underline emphasis added.)
[40] Provider #2's Hearing Request (April 15, 2010) at Tab 3, page 1 (citing *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996) and certain testimony given at the Board hearing held for PRRB Case Nos. 96-1882, 97-1579, 98-1827, and 99-2061). Provider #2's description of this issue is that "If the denominator of

3. SSI entitlement data not in agreement with Provider's Records (*Loma Linda* issues[41])
4. Fundamental Problems with SSI Percentage Calculation (*Baystate* issues[42])
5. Covered Days vs. Total Days in the denominator of the SSI fraction.[43]

The written description of these issues in the hearing request does not mention or identify the Part C Days issue (much less express a desire to have those days counted or included in the Medicaid fraction which is how the issue is framed in the group appeal[44]). Similarly, the estimated impact of the appeal request required under 42 C.F.R. § 405.1835(b)(2) confirms that the appeal only impacted the SSI fraction and does not include any reference to or suggestion that Part C days were implicated.[45] Finally, in support of its finding that Provider #2's appeal request fails to include the Part C issue, the Board notes that the record confirms that Provider #2 was well aware of the Part C issues when it filed its appeal on September 1, 2009 because, earlier in October 2008, it had drafted a request to add this very issue to an appeal for an earlier fiscal year.[46] Accordingly, the Board finds that Provider #2's hearing request did not include the Part C Days issue as required for Board jurisdiction under 42 C.F.R. § 405.1835(b) (a hearing request

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the SSI fraction includes days that were not paid by Medicare, then *the numerator of the SSI fraction* ***should include*** days for patients that may not have received payment as well." *Id.* at Tab 3, page 2 (emphasis added).

[41] *See id.* (citing *Loma Linda Comty Hosp. v. Dep't of Health & Human Servs*, 907 F. Supp. 1399 (C.D. Cal. 1995)).

[42] *Baystate* issues involve the data matching process used to calculate SSI percentages. *See id.* at Tab 3, pages 2-3 (citing to *Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006) and proceedings in *Baystate Med. Ctr. v. Leavitt*, 587 F. Supp. 2d 44 (2008) largely upholding that Board decision).

[43] Provider #2's description of this issue is: "By using total Medicare days in the denominator, the SSI percentage is deflated due to the inclusion of both Medicare Part A and Part B days." *Id.* (citing to 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004 for the CMS policy at issue)).

[44] The group appeal request for Case No. 10-0924GC dated April 13, 2010 describes the group issue as follows:

> Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, the Medicaid days proxy, set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations. . . . The intermediary failed to include patient days applicable to Medicare Managed Care Part C patients who were also eligible for Medicaid in the Medicaid fraction for Medicare DHS payment adjustment calculation purposes.

However, this was not discussed in Provider #2's individual appeal request filed September 1, 2009 (nor timely added to that individual appeal) under Case No. 16-0067.

[45] *See* Provider #2's Request for Hearing (April 15, 2010) at Tab 5. The Board notes that 42 C.F.R. § 405.1835(b) specifies that a providers hearing request "must include" among other things: "If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and *the reimbursement or payment sought for the item*." (Emphasis added.)

[46] Provider ## 1 and 2 are the ***same*** provider but involve different fiscal years, FYs 2005 and 2007 respectively. As previously discussed, Provider #1 allegedly filed a *detailed* request to add the Part C issue to its FY 2005 appeal in October 2008 confirming that it was aware of the Part C issue as well as how to calculate the estimated reimbursement amount for that issue but failed to include that issue in its September 1, 2009 FY 2007 request for hearing. *See supra* notes 36, 37 and accompanying text. Similarly, the September 1, 2009 FY 2007 request for hearing includes cites to Board hearings, Board decisions, preamble discussions in final rules published in the Federal Register, and court proceedings and decisions. In light of this, it is significant that Provider #2's request for hearing does not: (1) reference or discuss those portions of the preamble in either the final rule published on August 11, 2004 discussing the Part C Days policy (*see* 69 Fed. Reg. at 49099) or the final rule published on August 22, 2007 codifying this policy into the C.F.R (*see* 72 Fed. Reg. 47130, 47383-47409, 47411 (Aug. 22, 2007)); or (2) cite to any cases involving Part C days issues that discuss either of these preamble discussions (*see, e.g., SRI 1998 DSH Medicare Part C Days Group v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2009-D30 (July 9, 2009)).

must include an explanation of each specific item at issue) and Board Rule 8.1.A. (some issue may have multiple components, each contested component must be appealed as a separate issue and described as narrowly as possible and HMO or Medicare Part C is specifically identified as one of the components that must be separately identified). Since Provider #2 did not appeal the Part C issue or timely add the issue, Provider #2 could not transfer the issue to Case No. 10-0924GC via the April 12, 2010 transfer request. Accordingly, the Board hereby dismisses Provider #2 Covenant Medical Center (Provider No. 16-0067, FYE June 30, 2007) from Case No. 10-0924GC. Since jurisdiction over a provider is a prerequisite to granting a request for EJR, the Board also denies the Provider #2's request for EJR.[47]

Conclusion

The Board hereby dismisses the appeals for the 2005 and 2007 fiscal years for Covenant Medical Center from Case No. 10-0924GC and, as jurisdiction is a prerequisite for EJR, dismisses case, the Board hereby denies the EJR for those appeals. As there are no other providers remaining in Case No. 10-0924GC, the Board hereby closes Case No. 10-0924GC 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.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

8/2/2019

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS
Wilson Leong, FSS

[47] *See* 42 C.F.R. § 405.1842(a).

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Community Health Systems
Nathan Summar
Vice President, Revenue Management
4000 Meridian Boulevard
Franklin, TN 37067

Novitas Solutions, Inc.
Bruce Snyder
Director, JL Provider Audit & Reim.
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: Tyler Memorial Hospital (Provider No. 39-0192)
FYE 06/30/2007
Case No. 16-1823

Dear Mr. Summar and Mr. Snyder,

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

**Background**

Tyler Memorial Hospital is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in a Notice of Correction of Program Reimbursement ("Revised NPR") dated December 10, 2015 for fiscal year end ("FYE") 06/30/2007. The Provider timely filed an appeal from the revised NPR on April 26, 2016. The Model Form A-Individual Appeal Request presented two issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH—Medicaid Eligible Days

The Provider also filed a Model Form E Request to join an existing group appeal for the SSI Systemic Errors issue in Case No. 13-0151GC. The Medicare Contractor filed a jurisdictional challenge over the Medicaid Eligible days issue.

**Medicare Contractor's Contentions**

The Medicare Contractor asserts that the Board does not have jurisdiction over the Medicaid Eligible days issue because the adjustment (Adjustment 4) cited by the Provider as the source of dissatisfaction, adjusted the SSI percentage and DSH percentage.[1] However, no changes were

[1] Medicare Administrative Contractor's Jurisdictional Challenge at 1.

made to the Medicaid Eligible Days.[2] Additionally, the Medicare Contractor argues that it did not render a final determination in regards to Medicaid Eligible Days.[3]

**Provider's Contentions**

The Provider argues that the Board does have jurisdiction over the Medicaid Eligible Days issue because of the issuance of an NPR and timely appeal.[4] Further, the adjustments to DSH were enough to warrant Board jurisdiction over the issues in this appeal; however, the adjustments to DSH are not required because it is not an item that has to be adjusted or claimed on a cost report.[5]

**Board's Decision**

The Board finds that it does not have jurisdiction over the two issues that remain pending in this appeal because the SSI Provider Specific issue is duplicative of an issue in a group appeal, and the Provider appealed from a revised NPR in which there was no specific adjustment made to Medicaid Eligible Days.

*SSI Provider Specific*

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue. The jurisdictional analysis for this issue has two relevant components: 1) the Provider disagreed with the Medicare Contractor's computation of the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider reserving the right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The Provider's disagreement with the Medicare Contractor's computation of SSI percentage is duplicative of the DSH SSI Data Match issue that the Provider directly added to group appeal 13-0151GC (Community Health Systems 2007 Post 1498 DSH SSI Data Match CIRP Group). The Provider's SSI Provider Specific issue questions "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation.[6] The Provider's legal basis argues that ". . . its(sic)SSI percentage published by the Centers for Medicaid Services ('CMS') was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation," and that ". . . the SSI percentage issued by CMS is flawed."[7]

The group appeal's DSH SSI Data Match issue argues that the Fiscal Intermediary and the centers for Medicare and Medicaid Services failed, ". . . to properly determine the ratio of patient days for patients entitled to Medicare Part A and supplemental Security Income (SSI)

[2] *Id*.
[3] *Id*. at 2.
[4] Provider's Jurisdictional Response at 2.
[5] *Id*.
[6] Provider's Individual Appeal Request Tab 3, Issue 1
[7] *Id*.

benefits . . . ."[8] Essentially, the Provider is arguing that its SSI percentage is inaccurate, which makes this issue duplicative of Issue 1 in the instant case.

CMS regulation interpretation applies to all SSI calculations and is not specific to this Provider. Because this Provider is part of a chain, the Provider is required CIRP to pursue this issue in a CIRP group. Based on the above, the Board finds that it does not have jurisdiction over the first aspect of the SSI Provider Specific issue, as it is duplicative of the SSI Systemic Errors issue that is being pursued in a CIRP group.

The second component of Provider Specific Issue (the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period) is dismissed by the Board due to a lack of jurisdiction. Pursuant 42 C.F.R. § 412.106(b)(3), when determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . ." Without a written request, the Medicare Contractor cannot issue a final determination that Provider can use to prove dissatisfaction during an appeal, therefore the Board dismisses this aspect of the SSI Provider Specific issue.

*Medicaid Eligible Days*

The Board finds that it does not have jurisdiction over the Medicaid eligible days issue because it was not adjusted in the Provider's revised NPR.

In certain instances, there is an opportunity for revisions to a final determination (e.g., a revised NPR). In this regard, 42 C.F.R. § 405.1885 (2015) states that:

> (a) *General*. A secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific finding s on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to the contractor determinations), or by the reviewing entity that made the decision (as described in paragraph (c) of this section).

42 C.F.R. § 405.1889 further explains the circumstances under which revised determinations are appealable:

> (a) If a revision is made in a Secretary of intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. 405.1811, 405.1834, 405.1835, 405.1837, 405.1975, 405.1877, and 405. 1885 of this subpart are applicable.

[8] Group Appeal Request for 13-0151GC at Tab 2.

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

In accordance with these regulations, a Provider can only appeal items that were specifically adjusted in the revised NPR. Here, the Medicaid Eligible Days were not adjusted. Rather, the primary adjustments were made to update the SSI and DSH percentages, correct mathematical errors, and complete cost reporting forms and pages. As the revised NPR is a distinct determination and no adjustments were made to the Medicaid eligible Days, the Board finds that it does not have jurisdiction over this issue and hereby dismisses the issue from this appeal.

**Conclusion**

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative off the SSI Systemic Errors issue transferred to a group and because there is no final determination with respect to the realignment portion of the issue statement. The Board also finds that it does not have jurisdiction over the Medicaid Eligible Days issue as there was no specific adjustment made to the Medicaid Eligible Days in the revised NPR on which the Provider bases this appeal.

As no issues remain pending in this appeal, the Board hereby closes Case No. 16-1823 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/2/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
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**Via Electronic Delivery**

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RE: Baylor Medical Center at Waxahachie (Provider No. 45-0372)
FYE 06/30/2007
Case No. 16-1949

Dear Mr. Galinsky and Mr. Lattimore,

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

**Background**

Baylor Medical Center at Waxahachie is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in a Notice of Correction of Program Reimbursement ("Revised NPR") dated December 30, 2015 for fiscal year end ("FYE") 06/30/2007. The Provider timely filed an appeal from the revised NPR on June 29, 2016. The Model Form A-Individual Appeal Request presented nine issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI (Systemic Errors)
3. DSH—SSI Fraction/ Medicare Managed Care Part C Days
4. DSH—SSI Fraction/Dual Eligible Days
5. DSH—Medicaid Fraction/ Medicare Managed Care Part C Days
6. DSH—Medicaid Fraction/ Dual Eligible Days
7. DSH—Medicaid Eligible Days
8. DSH—Medicare Managed Part C Days
9. DSH—Dual Eligible Days

On February 27, 2017, the Board received requests to transfer issues to group appeals for the following issues:

- DSH/SSI Systemic Errors, PRRB Case No.: 13-3926GC
- SSI Fraction/Medicare Managed Care Part C Days, PRRB Case No.: 13-3929GC

- Medicaid Fraction/Medicare Managed Part C Days, PRRB Case No.: 13-3918GC[1]
- SSI Fraction/Dual Eligible Days, PRRB Case No. 13-3938GC
- Medicaid Fraction/Dual Eligible Days, PRRB Case No. 13-3896.

The Medicare Contractor submitted a jurisdictional challenge over six issues: 1) SSI Provider Specific; 2) Medicaid Fraction/ Part C Days; 3) Dual Eligible Days; 4) Medicaid Eligible Days; 5) Medicare Managed Part C Days; and 6) Dual Eligible Days.

**Medicare Contractor's Contentions**

The Medicare Contractor asserts that the Board does not have jurisdiction over the following issues: 1) SSI Provider Specific; 5) Medicaid Fraction/Medicare Managed Care Part C Days; 6) Medicaid Fraction/ Dual Eligible Days; 7) Medicaid Eligible Days; 8) Medicare Managed Care Part C Days; 9) Dual Eligible Days.[2]

The Medicare Contractor argues that Issue 1 (SSI Provider Specific) should be dismissed because it is duplicative of Issue 2 (SSI Percentage).[3] Furthermore, the Medicare contractor contends that Issue 1 includes the Provider's subsidiary appeal over SSI realignment.[4] The Medicare Contractor asserts that SSI realignment is a hospital election.[5] Once the election is made, the hospital is bound by that decision, regardless of reimbursement impact.[6] Finally, the Provider's appeal is premature as there has been no final determination.[7]

The Medicare Contractor contends that the revisions cited by the Provider as sources of dissatisfaction (Adjustments 4, 5, 7, and 8) ". . . deal solely with updating the SSI percentage in various parts of the cost report," and that "[n]one of the adjustments render a final determination with respect to the Medicaid ratio issues."[8]

With regard to Issues 8 (Medicare Managed Part C Days), the Medicare Contractor argues that it is duplicative of the problems addressed by the Provider in Issues 3 and 5.[9] Similarly, the Medicare Contractor contends that Issue 9 (Dual Eligible Days) is duplicative of Issues 4 and 6.

**Provider's Contentions**

*SSI Provider Specific*

The Provider argues that Issue 1 (SSI Provider Specific) and Issue 2 (SSI Systemic Errors) are not duplicative as they address "separate and distinct" issues.[10] The Provider cites Board Rule

[1] The Board granted EJR in Case Nos. 13-3918GC and 13-3939GC on April 8, 2019.
[2] Medicare Contractor's Jurisdictional Challenge at 1.
[3] *Id*.
[4] *Id*. at 2.
[5] *Id*.
[6] *Id*.
[7] *Id*.
[8] *Id*. at 3.
[9] *Id. at 5.*
[10] Provider's Jurisdictional response at 1.

8.1 as support of its argument that Issues 1 and 2 represent different components of the SSI issue, meaning that they are not duplicative.[11] The Provider states that Issue 2 addresses ". . . the various issues discussed in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) in CMs' calculation of the disproportionate payment percentage. . .", while Issue 1 addresses ". . . various errors of omission and commission that do not fit in the 'systemic errors' category."[12]

*Medicaid Eligible Days*

The Provider asserts that there was an adjustment made to its DSH (Audit Adjustment 5), and that this adjustment is enough to give the Board jurisdiction over the issue.[13] Further, the Provider states, that an ". . . adjustment is not required, as DSH is not an item that has to be adjusted or claimed on a cost report.[14]

*Consolidation of Duplicate Issues*

The Provider agrees that there are duplicate issues in the appeal. The Provider requests that Issue 5 (Medicaid Fraction/Medicare Managed Care Part C Days) be consolidated with Issue 8 (Medicare Managed Part C Days). The Provider also requests that Issue 6 (Medicaid Fraction/ Dual Eligible Days) be consolidated with Issue 9 (Dual Eligible Days).[15]

**Board's Decision**

The Board finds that it does not have jurisdiction over the two issues that remain pending in this appeal.

*SSI Provider Specific*

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue. The jurisdictional analysis for this issue has two relevant components: 1) the Provider disagreed with the Medicare Contractor's computation of the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider's request to reserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The Provider's disagreement the Medicare Contractor's computation of SSI percentage is duplicative of the Systemic issue that the Provider transferred to a group appeal 13-3926GC (QRS BHCS 2007 DSH SSI Percentage CIRP Group). The Provider's DSH payment (Provider Specific) issue questions "[w]hether the Medicare Administrative contractor ('MAC') used the correct Supplemental security Income ('SSI') percentage in the Disproportionate Share Hospital ('DSH') calculation.[16] The Provider's legal basis argues that ". . . its(sic) SSI percentage

[11] "Some issues may have multiple components. To comply with the regularity requirement to specifically identify the items in dispute, each contested item must be appealed as a separate issue and described as narrowly as possible. . ." Board Rule 8.1.
[12] *Id*. at 2.
[13] *Id*. at 3.
[14] *Id*.
[15] Provider's Jurisdictional Response at 8.
[16] Provider's Individual Appeal Request Tab 3, Issue 1.

calculated by the Centers for Medicare and Medicaid Services ('CMS') was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation." and that ". . . the SSI percentage issued by CMS is flawed."[17]

The Provider's SSI Systemic Issue concerns "[w]hether the Secretary properly calculated the Provider's Disproportionate Share Hospital ('DSH')/ Supplemental Security Income ('SSI') percentage."[18] Further, the ". . . providers contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ('CMS') and used by the Lead Mac to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008). . . ."[19] Essentially, the Provider is arguing that its SSI percentage is inaccurate, which makes this issue duplicative of Issue 1 in the instant case.

CMS regulation interpretation applies to all SSI calculations and is not specific to this Provider. Because this provider is part of a chain, the provider is required CIRP regulations to pursue this issue in a CIRP group.

The second component of the Provider Specific issue (the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period) is dismissed by the Board due to a lack of jurisdiction. Pursuant to 42 C.F.R. §412.106(b)(3), when determining a provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the federal fiscal year, it must furnish to CMS, through its intermediary, a written request. . . ." Without the written request, the Medicare Contractor cannot issue a final determination that the provider can use to prove dissatisfaction during an appeal.

*Medicaid Eligible Days*

The Board finds that it does not have jurisdiction over this issue as there was no adjustment made to Medicaid Eligible Days on the revised NPR on which the Provider based this appeal.

In certain instances, there is an opportunity for revisions to a final determination (e.g., a revised NPR). In this regard, 42 C.F.R. § 405.1885 (2015) states that:

> (a) *General*. A secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific finding s on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to the contractor determinations), or by the reviewing entity that made the decision (as described in paragraph (c) of this section).

42 C.F.R. § 405.1889 further explains the circumstances under which revised determinations are appealable:

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[17] *Id*.
[18] Provider's Individual Appeal Request Tab 3, Issue 2.
[19] *Id*.

> (a) If a revision is made in a Secretary of intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. 405.1811, 405.1834, 405.1835, 405.1837, 405.1975, 405.1877, and 405. 1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised may not be considered in any appeal of the revised determination or decision.

In accordance with these regulations, a provider can only appeal items that were specifically adjusted in the revised NPR. Here, the Medicaid Eligible Days were not adjusted. Rather, the primary adjustments were made to correct mathematical errors, adjust the SSI ratio, and adjust the DSH percentage. As the revised NPR is a distinct determination and no adjustments were made to the Medicaid Eligible Days, the Board finds that it does not have jurisdiction over this issue.

*Consolidation of Duplicate Issues*

The Board agrees with the parties that Issue 8, Medicare Managed Care Part C Days, and Issue 9, Dual Eligible Days, are duplicative of the same issues that the Provider separately appealed for the Medicaid and SSI Fractions, and that have since been transferred to group appeals. The Provider transferred the Part C Days issue to Case Nos. 13-3918GC and 13-3929GC and, subsequently on April 8, 2019, the Board granted Expedited Judicial Review of these two group appeals which included Baylor Medical Center at Waxahachie as a participant. Therefore, the Medicare Managed Care Part C Days issue has been resolved for this Provider and is no longer pending in this appeal. Additionally, the Board hereby consolidates the Dual Eligible Days issue with the Medicaid and SSI fraction issues that were transferred to Case Nos. 13-3896GC and 13-3938GC, respectively.

Accordingly, the Medicare Managed Care Part C Days and Dual Eligible Days issues are no longer pending in this individual appeal.

**Conclusion**

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue that is being pursued in a CIRP group and because there is no final determination with respect to the realignment portion of the issue statement.

The Board also finds that it does not have jurisdiction over the Medicaid Eligible Days issue as the Provider's revised NPR did not adjust the Medicaid Eligible Days.

As no issues remain pending in this appeal, the Board hereby closes Case No. 16-1949 and removed it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

For the Board:

8/2/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Mail**

Robert McCue
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Brunswick, ME 04011

RE: ***Jurisdictional Decision in Case No. 14-1051***
Mid Coast Hospital (Provider No. 20-0021, FYE 9/30/2006)

Dear Mr. McCue,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the appeal referenced above and finds that it does not have jurisdiction over the Qualified Medicare Beneficiary ("QMB") Crossover Bad Debt issue. The jurisdictional decision of the Board is set forth below.

**Pertinent Facts:**

The Medicare Contractor ("MAC") conducted a desk review of Mid Coast Hospital's ("Provider") cost report statement for Fiscal Year Ending ("FYE") September 30, 2006 and issued a preliminary adjustment report. Shortly thereafter, the Provider informed the MAC that the bad debts were not accurately adjusted. The MAC agreed, and an adjustment report was finalized on July 23, 2012 with the bad debts properly included.[1] More specifically, the bad debts which were deemed allowable during the MAC's review were: (1) $90,894 inpatient Non-QMB claims; (2) $112,398 outpatient Non-QMB claims; and (3) $4,977 outpatient Non-QMB Manual claims.[2] The Crossover Bad Debt Review Summary and History worksheets submitted in this case all note at the bottom that "**The allowed amount is from the Non-QMB listing** that was provided by the state."[3] Likewise, the audit adjustment report prepared prior to the Notice of Program Reimbursement ("NPR") stated that the "allowed amounts are from the Non-QMN listing that was provided by the state"[4] even though some of those allowed amounts were inadvertently excluded from that NPR.

On November 9, 2012, the Provider was issued a NPR for the fiscal year at issue, but it did not include all of the bad debts finalized in the July 23, 2012 audit adjustment report.[5] Specifically, the MAC included the $4,977 outpatient Non-QMB Manual Claims on the cost report, but inadvertently excluded the adjustments associated with the $90,894 inpatient Non-QMB and $112,398 outpatient Non-QMB claims.[6]

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[1] *See* Medicare Administrative Contractor's Jurisdictional Challenge, Exhibit I-6 (Feb. 10, 2015).
[2] *Id.* at 2.
[3] Provider's Individual Appeal Request, Tab 1 (Revised NPR W/P); Medicare Administrative Contractor's Jurisdictional Challenge, Exhibits I-4 & I-8 (emphasis added).
[4] Medicare Administrative Contractor's Jurisdictional Challenge at Exhibit I-5.
[5] Provider's Individual Appeal Request at Tab 1.
[6] Medicare Administrative Contractor's Jurisdictional Challenge at 2.

As a result, on November 28, 2012, the Provider requested the MAC reopen its cost report to include the bad debts pursuant to the audit adjustment report.[7] On December 18, 2012, the MAC proceeded to issue a Notice of Reopening of Cost Report to include "bad debts that were determined to be allowable during the desk review, but were inadvertently left off the final audit adjustment report."[8] Ultimately, the MAC issued a Revised NPR ("RNPR") to include the two adjustments for the Non-QMB claims which had been inadvertently excluded from the NPR.

The Provider filed an appeal from the RNPR on November 27, 2013, seeking to include additional amounts of unpaid Inpatient and Outpatient QMB's to increase its allowable Reimbursable Bad Debt for Dual Eligible Beneficiaries.[9]

**Jurisdictional Challenge – Parties' Arguments:**

The MAC filed a Jurisdictional Challenge on February 10, 2015, arguing that there was no adjustment made by the MAC on the RNPR related to the Provider's appealed issue. They note that the reopening of Provider's cost report was to include "bad debts that were determined to be allowable during the desk review, but were inadvertently left off the final audit adjustment report."[10] The two adjustments that were inadvertently left off, and which had been deemed allowable during the MAC's audit, were related to Inpatient and Outpatient **Non-QMB** claims. Indeed, the MAC points out that the Inpatient and Outpatient **QMB claims** were deemed non-allowable during the MAC's audit – these claims were not "inadvertently left off" and were not the subject of the reopening; the RNPR made no adjustment to these claims. All of the workpapers and the original NRP adjustment report clearly indicate that the allowable amounts were related to the **Non-QMB** claims.[11] The MAC summarizes its argument by stating "[i]n the reopened cost report being appealed, the MAC made no adjustment to the cost report for unpaid inpatient or outpatient crossover (dual eligible) bad debts for [QMBs]," so there was no determination with respect to the Provider for the issue being appealed.[12]

The Provider filed a response to the Jurisdictional Challenge on March 2, 2015. The Provider attempts to broaden the scope of what was adjusted, and what they are appealing. They claim that they are appealing "Medicare Crossover (Dual Eligible) Bad Debts" due to the adjustment on the cost report, which is entitled "Reimbursable Bad Debts for Dual Eligible Beneficiaries." Since the RNPR did not include all of the Provider's allowable "Bad Debts for Dual Eligible Beneficiaries," they claim the door has been opened for any such bad debt.

**Board's Decision:**

As set forth below, the Board finds that it does not have jurisdiction over the QMB Crossover Bad Debt issue because the matter was not specifically revised in the MAC's reopening.

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[7] *Id.* at Exhibit I-6.
[8] *Id.* at Exhibit I-3.
[9] Provider's Individual Appeal Request at Tab 3.
[10] Medicare Administrative Contractor's Jurisdictional Challenge at Exhibit I-3.
[11] *Id.* at Exhibits I-4, I-5, & I-7.
[12] *Id.* at 3.

The Code of Federal Regulations provides for an opportunity for a reopening of a final determination for revisions (such as an RNPR). In this regard, 42 C.F.R. § 405.1885 (2018) states 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)[13] explains what can be appealed from a revised determination:

> (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.

As outlined above, 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[.]"[14] The reopening in this case was requested by the Provider to include two specific adjustments which had previously been deemed allowable: (1) $90,894 inpatient Non-QMB claims; and (2) $112,398 outpatient Non-QMB claims.[15] The Notice of Reopening explicitly stated that the purpose of the reopening was to include "bad debts that were determined to be allowable during the desk review, but were inadvertently left off the final audit adjustment report."[16] In other words, the determination was only being reopened to include these two specific adjustments for allowable Non-QMB claims, which were inadvertently excluded from the NPR. It was not reopened to reconsider crossover bad debts, generally. All of the workpapers and the initial NPR adjustment report make clear that QMB claims were deemed non-allowable from the start, and there is no indication that these amounts were intended to be (or actually were) revised in the reopening. Since the only matters specifically revised in the RNPR were adjustments related to Non-QMB claims, the Board does not have jurisdiction from an appeal of that RNPR with regard to QMB claims.

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[13] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[14] 42 C.F.R. § 405.1889(b)(1).
[15] Medicare Administrative Contractor's Jurisdictional Challenge at Exhibit I-6.
[16] *Id.* at Exhibit I-3.

Since the Provider's appeal only seeks the inclusion of QMB claims on its cost report, the Board concludes that it does not have jurisdiction over the QMB Crossover Bad Debt issue in this appeal because the MAC did not specifically revise that item in the reopening. As the QMB Crossover Bad Debt issue is the only issue in the appeal, the Board hereby closes the referenced appeal and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

8/2/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Joanne Erde
Duane Morris
200 South Biscayne Blvd., Suite 3400
Miami, FL 33131

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

**RE:** ***Jurisdictional Determination in Case No. 14-1010***
Sarasota Memorial Hospital IRF LIP (Provider No. 10-0087, FYE 9/30/2008)

Dear Ms. Erde and Mr. Pike:

This case involves the Providers' appeal of its Medicare reimbursement for the fiscal year ending September 30, 2008 ("FY 2008"). The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation on its own motion in response to the 2018 decision of the U.S. Court of Appeals, District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the related issues within the instant appeal. There is one remaining issue in Case No. 14-1010, and it will remain open and proceed in due course.

## Pertinent Facts

*PRRB Case No. 14-1010 – Sarasota Memorial Hospital (10-0087) FYE 09/30/2008*

The Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2008. In its RFH, the Providers' list multiple issues for appeal, all relating to one subject — the calculation of the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

The Provider appeals the following components of LIP:

- **SSI** – Whether the MAC used the correct SSI% in the Provider's IRF LIP adjustment.[2]
- **Medicaid Eligible Days** – Whether the MAC included all Medicaid-eligible days in the IRF LIP adjustment.

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).
[2] *See* Provider Request for Appeal, PRRB Case Nos. *17-1991*.

- **Medicare Managed Care Part C Days** – Whether Medicare Part C Days were properly accounted for in the IRF LIP adjustment.
- **Dual Eligible Days** – Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the IRF LIP adjustment.

Accordingly, the LIP adjustment for IRF comprises four of the five issues in Case No. 14-1010.

## Board's Analysis and Decision

### Applicable Regulatory Provisions and Board Rules

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

### Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy*, answers this question and clarifies what is shielded from review in its analysis of this issue.[3]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[4] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's

[3] *Id*.
[4] *Id.* at 1064.

determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[5] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[6]

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issues in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the D.C. Circuit decision in *Mercy* is controlling precedent for interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[7]

There is one remaining issue in Case No. 14-1010, and the appeal will remain open and proceed in due course. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/2/2019

X Clayton J. Nix

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

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

[5] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[6] *Mercy*, 891 F.3d at 1068.
[7] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Healthcare Reimbursement Services, Inc.
Corinna Goron
President
c/o Appeals Department
17101 Preston Road, Suite 200
Dallas, TX 75248-1372

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

**RE:** ***Jurisdictional Determination***
North Oaks Rehabilitation Hospital (Provider No. 19-3044)
FYEs: 06/30/2012, 06/30/2013, 06/30/2014
Case Nos.: 14-3901, 15-3151, 17-0451

Dear Ms. Goron and Mr. Lattimore:

This case involves the Provider's appeals of Medicare reimbursement for the fiscal years ending ("FYE") on June 30, 2012, June 30, 2013, and June 30, 2014. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Low Income Payment ("LIP") issues and dismisses all three appeals.

## Pertinent Facts

On July 30, 2014, the Board received the Provider's Individual Appeal Request for the cost reporting period ending on June 30, 2012; the Board assigned Case No. 14-3901. In this appeal request, the Provider presented one issue with four subparts concerning its LIP adjustment. These subparts addressed:

1. LIP—SSI
2. LIP—Medicaid Eligible Days
3. LIP—Medicare Managed Part C Days
4. LIP—Dual eligible Days.[1]

On July 30, 2015, the Provider submitted an Individual Appeal Request for fiscal year end June 30, 2013; the Board assigned Case No. 15-3151. In this appeal, the Provider presented the same issue and subparts as the prior year's appeal.[2] Additionally, on November 10, 2016, the Board

[1] Provider's Individual Appeal Request, Case No. Tab 3.
[2] *See* PRRB Case No. 14-3901

received the Provider's Individual Appeal Request for fiscal year end June 30, 2014; the Board assigned Case No. 17-0451. This appeal also presented the same issue and subparts as Case No. 14-3901.

The Medicare Contractor filed jurisdictional challenges in all three appeals and the Provider's representatives filed responses.

## Board's Analysis and Decision

### Applicable Regulatory Provisions and Board Rules

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

### IRF LIP Adjustment

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the decision of the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*") answers this question and clarifies what is shielded from review in its analysis of this issue.[3]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the

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

establishment of the hospital's prospective payment rates.[4] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[5]

In the instant appeals, the Provider seeks that the Board determine that the Medicare Contractor: 1) incorrectly computed its SSI percentage; 2) failed to include all Medicaid Eligible Days; 3) improperly accounted for the Medicare Managed Care Part C Days; and 4) failed to include all Dual Eligible Days in the IRF LIP Adjustment.[6] As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeals of the LIP adjustment and dismisses the issue and subparts in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the D.C. Circuit's decision in *Mercy* is controlling precedent for interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[7] As no issues remain pending in the appeal, the Board hereby closes Case Nos. 14-3901, 15-3151, and 17-0451 and removes them from the Board's docket.

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

**BOARD MEMBERS PARTICIPATING:**

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

FOR THE BOARD:

8/7/2019

X Clayton J. Nix

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

[4] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).
[5] *Mercy*, 891 F.3d at 1068.
[6] Provider's Individual Appeal Request Tab 2.
[7] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Via Electronic Mail**

James Ravindran, President
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue
Arcadia, CA 91006

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

Re: Integris Southwest Medical Center, Provider No. 37-0106, FYE 06/30/2007, Case No. 19-2311

Dear Messrs. Ravindran and Lattimore:

The Provider Reimbursement Review Board ("Board") is in receipt of the Provider's appeal request. The pertinent facts of the case and the Board's determination are set forth below.

**Pertinent Facts**:

Quality Reimbursement Services ("QRS") filed an appeal on July 29, 2019 on behalf of the Provider using the Office of Hearings Case Document Management System ("OH CDMS"). The appeal was filed on the 185th day from the date of the revised Notice of Program Reimbursement ("RNPR") dated January 25, 2019.

The documents uploaded to the system in support of the final determination were 2 copies of the Provider's **original NPR** (one of which was marked as the "primary determination"). *Note: Although the date of the prior NPR is one of the entries required on the Model Form, the Rules do not require that the prior NPR be submitted. Instead, when filing from a RNPR, Board Rule 7.1.2.1 requires that the Provider upload a copy of the Notice of Reopening (and the Request for Reopening where one was made).* In this case, instead of uploading the Reopening Notice, QRS submitted a statement that the RNPR ". . . was issued in compliance with the District Court remand ordering the MAC to implement 1492-R." The same statement was also uploaded in lieu of audit adjustment support.

The Appointment of Designated Representative letter filed with the appeal was dated December 23, 2009 (almost 10 years ago) and is issue specific for SSI – and specifically excludes HMO days (which are 2 of the issues included in the appeal.)

**Decision of the Board**

The Board finds that the Provider's appeal request is jurisdictionally deficient as the Provider failed to submit the final determination (in this case, the RNPR) under appeal.

Pursuant to 42 C.F.R. § 405.1835(b), if a Provider's appeal request does not meet the requirements of paragraph (b)(3) of the same section, the Board may dismiss with prejudice the appeal, or take any other remedial action it considers appropriate. Paragraph (b)(3) states in part that the following must be included in the Provider's request:

> A copy of the determination, including any other documentary evidence the provider considers necessary to satisfy the hearing request requirements.

The RNPR was issued on January 25, 2019 – so the Representative had 6 months to obtain a copy.

Further, the appeal has a separate fatal deficiency. The Representation letter (which is almost 9 years old and is outdated) does not meet the requirements of Board Rule 5.4 in that it is issue specific and does not cover 5 of the 7 issues under appeal and actually *excludes* representation over 2 of the issues involving Part C Days.

Because the Provider not only failed to submit a copy of the final determination under appeal, the Notice of Reopening and the applicable audit adjustment pages, but also provided an unacceptable Representation Letter, the Board finds that the Provider did not meet the regulatory requirements for filing an appeal before the Board.

Accordingly, the Board finds dismissal is appropriate and hereby closes Case No. 19-2311. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/7/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Mail

Gerd Kerswill, CFO
Assisted Home Care, Inc.
72 Moody Court
Suite 100
Thousand Oaks, CA 91360

Danene Hartley, Appeals Lead
National Government Services, Inc. (J-6)
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Assisted Home Care, Inc., Provider No. 05-1634
Hospice Cap Period: 11/1/2013-10/31/2014, PRRB Case No. 19-2301
Hospice Cap Period: 11/1/2014-10/31/2015, PRRB Case No. 19-2302
Hospice Cap Period: 11/1/2015-10/31/2016, PRRB Case No. 19-2304
Hospice Cap Period: 11/1/2016-09/30/2017, PRRB Case No. 19-2305

Dear Mr. Kerswill and Ms. Hartley:

The Provider Reimbursement Review Board (the "Board" or "PRRB") has established four cases for Assisted Home Care, Inc. (the "Provider"), to which it has assigned Case Nos. 19-2301, 19-2302, 19-2304, and 19-2305. The pertinent facts with regard to these cases and the Board's determination are set forth below.

**Pertinent Facts:**

On November 15, 2018, the Medicare Contractor issued Notices of Reopening Review of Hospice Cap for the cap periods ending 10/31/2014, 10/31/2015, and 10/31/2016. On December 27, 2018, the Medicare Contractor issued a Final Notice of Review of Hospice Cap for the final cap period ended 09/30/2017.

Although a formal appeal was not filed with the Board (via mail or through the Office of Hearings Case & Document Management System ("OH CDMS")), the Provider contacted the OH CDMS Help Desk ("Help Desk") several times, presumably, to get information on filing an appeal. Below is a summary of the Provider's interaction with the Help Desk.

- The first record of any contact from the Provider was a phone call to the Help Desk on June 11, 2019, requesting assistance to reactivate the user account. This request was completed by the Help Desk and confirmed by the Provider on June 12, 2019. The Help Desk ticket was deemed complete and closed on June 17, 2019.

- The Help Desk indicates that a second phone call occurred on June 19, 2019. As part of this call, the Help Desk requested that the Provider submit an email with specific questions. An email was not immediately received in response to this request, but it was later determined that the Provider sent the email to an incorrect email address.[1]

- The next documented contact was made a week later, on June 26, 2019, when the Provider indicated, via email, that it was "re-sending the documents to the correct address." Attached to this email were four Notices of Review of Hospice Cap for the cap years 2014 through 2017, but there was no narrative or other clarification as to what the Provider wished the Help Desk to do with these documents.

- On June 26, 2019, the Help Desk replied by email to the Provider, stating:

> Additional Information Needed
> We received your email that had a document attached but there [were] no questions included in the email. Would you please let us know exactly what your question regarding this document is so we can relay it to the correct people and get your questions answered. Please contact the Helpdesk if you have any questions or additional information to add.

- On July 1, 2019, the Help Desk sent a follow-up email that said:

> Additional Information Needed
> We still need more information about your request. Please email us back with the questions you had about your previous submission. Please contact the Helpdesk if you have any questions or additional information to add.

- The Provider responded to the Help Desk inquiries by phone call on July 2, 2019, indicating that he would speak to his manager and then send questions pertaining to the attachment.

- On July 5, 2019, the Provider submitted an email to the Help Desk. This correspondence reattached the Notices of Review of Hospice Cap previously submitted and the following narrative in the body of the email:

> THANK YOU VERY MUCH FOR YOUR GUIDANCE AND DIRECTIONS. PER OUR RECENT PHONE CONVERSATION, PLEASE OPEN A CASE WITH THE PRRB FOR THE

[1] The initial email was sent to HELPDESK_OHCDMS@CMS.AHHS.GOV rather than HELPDESK_OHCDMS@CMS.HHS.GOV.

> FOLLOWING REASON. WE ARE DISPUTING THE ADJUSTMENT TO OUR CAP REPORTS FOR PROVIDER 05-1634 FOR PERIODS ENDING 09/30/2017, 10/31/2016, 10/31/2015, AND 10/31/2014. WE WOULD LIKE JUSTIFICATION AS TO WHY THE AMOUNTS HAVE CHANGED PER YOUR NOTICES DATED 11/15/2018. (Emphasis in original.)

- Upon receipt of this correspondence, the Help Desk forwarded the inquiry to the Board.

Based on the July 5, 2019 communication to "please open a case with the PRRB," the Board opened cases for the 2014 – 2017 hospice cap years.

**Board Determination**:

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

Specifically, 42 C.F.R. § 405.1835(a)(3) indicates that, unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing. Timely filing is determined based on the date of receipt by the Board per 42 C.F.R. § 405.1801(a) and Board Rule 4.5.

The Medicare Contractor issued the Provider's Notices of Reopening Review of Hospice Cap for the 2014, 2015, and 2016 cap periods on November 15, 2018. The presumed date of receipt of the notices by the Provider was five days later, or November 20, 2018. Accordingly, the 180 day period to file an appeal ended on Sunday, May 19th, 2019. However, pursuant to 42 C.F.R. § 405.1801(d)(3) and Board Rule 4.4.3, "[i]f the due date falls on a Saturday, a Sunday, a Federal legal holiday . . . the deadline becomes the next day that is not one of the aforementioned days.". Therefore, the due date to file an appeal for these periods was Monday, May 20th, 2019.

The Medicare Contractor issued the Provider's Notice of Final Review of Hospice Cap for the 2017 cap period on December 27, 2018. Following the timeliness rules identified above, the presumed date of receipt of the notice was January 1, 2019. The 180 day period to file an appeal ended on Sunday, June 30th, 2019, with a provision to extend the period to the next business day, July 1, 2019.

The first indication that the Provider wanted to pursue an appeal was not until July 5th, 2019. This was 227 days after the receipt of the 2014 – 2016 hospice cap notices and 185 days after the

receipt of the 2017 hospice cap notice. Thus, all four cases exceed the allowable 180 day filing period.

In addition, 42 C.F.R § 405.1835(b) specifically requires the Provider to include documentary evidence to demonstrate that the Provider satisfies the hearing request requirements as specified in paragraph (a). The regulation specifies that the appeal must be in writing; it must include an explanation of the Provider's dissatisfaction with the determination, why the payment is incorrect and how and why it should be determined differently; and must include a copy of the determination. The regulation authorizes the Board to dismiss with prejudice any appeal that does not comply.

Further, Board Rule 3.2 indicates that documents should be submitted electronically to the Board through OH CDMS or, if via hard copy, by regular mail, express or overnight courier or hand delivery. "The Board does ***not*** accept appeals or other correspondence submitted by email of fax."[2]

Finally, Board Rule 6.1 advises that the Provider should reference Model Form A for required information or follow the prompts in OH CDMS if filing electronically. This is the minimum information required to file an appeal. "The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b).[3]

In these cases, the appeal was not filed in writing to the Board, nor was a copy forwarded to the Medicare Contractor. The only submission on record is email contact between the Provider and the Help Desk, which was subsequently forwarded to the Board by the Help Desk but not by the Provider. The only explanation of the Provider's dissatisfaction is the July 5th statement to the Help Desk that the Provider is "disputing the adjustment to our Cap Reports. . . ." Instead of providing an explanation of its dissatisfaction with why the payment is incorrect, the Provider actually requested that *the Board* justify why the amounts changed as indicated in the Hospice Cap notices.

Because the July 5th communication does not meet the standards for a Board appeal, and does not comply with Board Rules 3.2 and 6.1, as well as 42 C.F.R. § 405.1835(b), the Board hereby denies jurisdiction over the case. Moreover, since the July 5th communication to the Help Desk was beyond the 180-day filing deadline, it is too late for the Provider to now file a perfected appeal request with the Board.

[2] (Emphasis added.) Board Rules effective August 29, 2018.
[3] *Id*.

Accordingly, the Board hereby closes Case Nos. 19-2301, 19-2302, 19-2304, and 19-2305 and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

For the Board:

8/7/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Via Electronic Mail**

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**RE:** ***Request to Form Group Appeal or, Alternatively, Reinstate Case No. 06-1198G***
Catholic Health Initiatives, Provider Nos.: 28-0009, 28-0060
FYE: 6/30/2003; 8/31/2003
Case No.: 06-1198G

Dear Messrs. Keough and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the Providers' Request for Formation of Group Appeal dated July 8, 2016 and related documentation in Case No. 06-1198G which involved 20 participants. As set forth more fully below, consistent with CMS Ruling 1498-R ("Ruling 1498-R"), the Board is denying both the Providers' request for formation of group appeal and the Providers' alternative request for reinstatement of Case No. 06-1198G and, accordingly, will neither establish a new group appeal nor reinstate Case No. 06-1198G. Notwithstanding, the Board has determined that the Medicare Contractor failed to follow the Board's original 1498-R "Standard Remand" Order dated March 6, 2014 as it relates to the two (2) following participants in Case No. 06-1198G:

1. Good Samaritan Hospital, Provider No. 28-0009, FYE 6/30/2003 ("Samaritan"); and
2. Bergan Mercy Medical Center, Provider No. 28-0060, FYE 6/30/3003 ("Bergan").

Accordingly, ***the Board hereby orders the Medicare Contractor*** *to recalculate the DSH payment adjustment for the following two providers as mandated by the March 6, 2014 Board Order* pursuant the Board's authority under both the "standard or default implementation procedure" specified in § 4.a of Ruling 1498-R and 42 C.F.R. § 405.1845(h). *If the Medicare Contractor refuses or fails to implement the Board's March 6, 2014 Order as it relates to Samaritan and Bergan* ***within 30 days of the date of this letter (i.e., by Friday, September 6, 2019)***, the Providers may petition the Board for a referral of this matter to CMS pursuant to 42 C.F.R. § 405.1868(c).

**Background**

On March 6, 2014, the Board issued a 1498-R "Standard Remand" Order to remand Case No. 06-1198G to the Medicare Contractor "for recalculation of the Providers' DSH adjustments." At issue in this matter is a request from the group representative to either establish a new group

appeal for Samaritan and Bergan or, in the alternative, reinstate the original group appeal, Case No. 06-1198G, for a subset of the original participants, namely Samaritan and Bergan.[1]

### *A. Overview of the Original Group Appeal under Case No. 06-1198G and the 1498-R Remand*

On March 17, 2006, the Group Representative submitted the original hearing request to establish the original group appeal under Case No. 06-1198G challenging the exclusion from the disproportionate patient percentage ("DPP") of labor/delivery room ("LDR") inpatient days.[2] On August 24, 2009, Samaritan requested to be directly added to Case No. 06-1198G. Similarly, on March 9, 2010, Bergan requested to be directly added to Case No. 06-1198G.

On April 28, 2010, CMS issued Ruling 1498-R to address, in part, "DSH appeals challenging the exclusion from the DPP of labor/delivery room (LDR) inpatient days"[3] and required the Board "to remand each qualifying appeal to the appropriate Medicare contractor."[4]

On November 16, 2010, the Providers requested Expedited Judicial Review ("EJR") relating to certain aspects of Ruling 1498-R. Concurrent with that request, the Providers submitted certain "additional documentation to further establish the Board's jurisdiction over the appeals from revised NPRs," including documentation and information specifically addressing the Board's jurisdiction over Samaritan and Bergan. On November 23, 2010, the Medicare Contractor submitted its brief in opposition to the Providers' EJR request; however, the Medicare Contractor did not respond to or comment on the additional jurisdictional documentation submitted concurrent with the Providers' EJR request. On November 16, 2010, the Board denied the Providers' EJR request.

On December 3, 2013, the Board informed the parties that it "recently began a review of [Case No. 06-1198G], as the Labor and Delivery Days issue is subject to CMS Ruling 1498-R." The Board sought jurisdictional documentation from the group representative on certain providers other than Samaritan and Bergan and required submission within 30 days. Significantly, the Board specifically sought comments from the Medicare Contractor on the Board's jurisdiction over all the participants in the group: "The [Medicare Contractor] is advised, by copy of this letter, to send any comments it may have regarding jurisdiction, in the same 30-day period." *The Medicare Contractor* did not respond to the Board's request and *did not submit any comments on jurisdiction to the Board whether for Samaritan, Bergan, or any other provider*.

The Board applied the "standard or default implementation procedure" specified in § 4.a of Ruling 1498-R to Case No. 06-1198G and, on March 6, 2014, issued the 1498-R "Standard Remand" Order for Case No. 06-1198G.[5] In this Order, the Board found that "this appeal satisfies the applicable jurisdictional and procedural requirements of 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1840." Accordingly, the Order remanded 20 remaining participants in

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[1] *See* Provider's Request to Form Group Appeal (Jul. 11, 2016).
[2] Provider's Request for Hearing (Mar. 17, 2006).
[3] CMS Ruling 1498-R at 12.
[4] *Id.* at 1.
[5] PRRB Letter of Standard Remand under Ruling 1498-R (Mar. 6, 2014).

Case No. 06-1198G (including Samaritan and Bergan) "to the [Medicare Contractor" for recalculation of the Providers' DSH adjustment."

### *B. The Medicare Contractor's Denial of Remand Following the 1498-R Standard Remand Order*

On January 13, 2016, the Medicare Contractor sent two letters, one regarding Samaritan and the other regarding Bergan, stating their determination that neither provider met the requirements for remand per Ruling 1498-R.[6] Specifically, for Good Samaritan, the Medicare Contractor stated:

> We have received the documentation to support additional disproportionate share hospital (DSH) payments for labor and delivery room days (L&D) pursuant to the remand request under the terms of CMS Ruling 1498-R. We have reviewed this documentation and we have determined it does not meet the requirements for the following reason(s):
>
> 1. Remand requirements per 1498-R were not met. *Appeal [to the Board] based on a reopening that did not remove L&D days*.[7]

Similarly, for Bergan Mercy Hospital, the Medicare Contractor stated:

> We have received the documentation to support additional disproportionate share hospital (DSH) payments for labor and delivery room days (L&D) pursuant to the remand request under the terms of CMS Ruling 1498-R. We have reviewed this documentation and we have determined it does not meet the requirements for the following reason(s):
>
> 1. Remand requirements per 1498-R were not met. L&D was not added as a specific issue to the individual appeal ([PRRB Case No.] 07-0272) and *the revised NPR did not specifically adjust L&D days*, it only added general Medicaid eligible days and removed total days. *L&D was added directly to the group [appeal before the PRRB]* after R.O. #2 [*i.e*., reopening #2].[8]

The Medicare Contractor included the following statement in each of the letters suggesting that Samaritan and Bergan had the right to request reinstatement of the original group appeal: "If you disagree with our determination, you have the right to resume your original appeal of this issue in accordance with 42 CFR 405.1801 – 405.1889." Significantly, the Medicare Contractor did not include any language in the letter to "inform the provider of its right to contractor or Board hearing . . . and that the provider must request the hearing within 180 days after the date of receipt of the notice" as required by 42 C.F.R. § 405.1803 for each "notice of amount of program reimbursement."

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[6] *See* Provider's Request to Form Group Appeal, at Ex. 1. (Jul. 11, 2016).
[7] Provider's Request to Form Group Appeal, at Ex. 1. (Jul. 11, 2016) (emphasis added).
[8] *Id*. (emphasis added).

In response to these letters, the group representative petitioned to the Board to form a group appeal, challenging the Medicare Contractor's final determination in those matters, or in the alternative, to reinstate the original appeal (Case No. 06-1198G, closed on March 6, 2014).[9] In their request, the group representative characterizes the issue as the Medicare Contractor's illegal refusal to perform its nondiscretionary duty to effect payment revisions under a final Board order.[10] The group representative notes that the Board, in its remand order, had found that the appeal and the providers satisfied the applicable jurisdictional and procedural requirements. The group representative maintains that the Medicare Contractor does not have discretion to decide not to comply with the Board's final order.[11] Further, they argued that the only situation when the Medicare Contractor is permitted to make jurisdictional findings after a remand by the Board is under the "alternative remand" procedure established under 1498-R, which was not utilized in this remand.[12] Finally, the group representative asserts that the Board has jurisdiction from these remand denials because they are final determinations, they are dissatisfied, and they are filed timely within 180 days.[13]

## Board Determination

### *A. Denial of the Provider's Request to Form Group Appeal or, Alternatively, Reinstate Case No. 06-1198G*

At the outset, the Board notes that the January 13, 2016 letters from the Medicare Contractor essentially denied the Board's remand under Ruling 1498-R based on its findings that: (1) neither Samaritan nor Bergan met the jurisdictional requirements for a Board hearing based on their appeal of a revised NPR; and (2) as a result, neither met the requirements for remand under 1498-R. The first finding is a typical jurisdictional finding that the Board (not a Medicare contractor) makes, pursuant to 42 C.F.R. § 405.1840, in any appeal pending before the Board.

The group representative is asking the Board to either open a new appeal based on the Medicare Contractor's January 13, 2016 determinations, or to reinstate the original appeal so that the challenge against the denials may move forward. Under 42 C.F.R. § 401.108(b)-(c) (2011), CMS Rulings are published under the authority of the CMS Administrator and serve as precedent final opinions and orders or statements of policy or interpretation. Accordingly, CMS Rulings are binding on all Department of Health and Human Services, Social Security Administration and CMS components that adjudicate matters under the jurisdiction of CMS,[14] including the Board pursuant to 42 C.F.R. § 405.1867.

Here, within CMS-1498-R, the CMS Administrator has spoken directly on the issue of Board jurisdiction over a provider's Labor and Delivery Days DSH issue and subjected that issue to mandatory remand.[15] In the present case, once the Board initially determined that the groups'

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[9] *Id*. at 1.
[10] *Id*. at Ex. 2, Issue Statement.
[11] *Id*.
[12] *Id*.
[13] *Id*. Further, the Providers assert that the Medicare Contractor's notice confirms Provider's appeal rights with regard to that final determination.
[14] 42 C.F.R. § 405.108(c) (2011).
[15] Ruling 1498-R at 6.

L&D days issue for fiscal year 2003 was within CMS-1498-R's mandates, the Board no longer had jurisdiction over the issue and was required to remand the issue to the Medicare Contractor. Nothing within CMS-1498-R suggests that the Board may reassume jurisdiction over this issue once it has been remanded.

In fact, CMS-1498-R states that upon remand, "CMS' action eliminates *any* actual case or controversy regarding the hospital's previously calculated L&D Days, SSI fraction, and DSH payment adjustment *and thereby renders moot* each properly pending claim in a DSH appeal involving the hospital's previously calculated SSI fraction and the process by which CMS matches Medicare and SSI eligibility data, provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines."[16] The Ruling further provides "that the [Board] and the other administrative tribunals lack jurisdiction over provider appeals of any of [these] three issues."[17] Accordingly, the Board was divested of its authority to act on this case as soon as the Board determined that the Providers' claims satisfied the applicable jurisdictional and procedural requirements for appeal and remanded the L&D Days issue to the Medicare Contractor. As a consequence of this divestiture, the Board must conclude that the case cannot be reinstated.[18]

Similarly, the Board finds that this matter is not yet ripe for formation of a group appeal because the January 13, 2016 letters from the Medicare Contractor addressing Samaritan and Bergan were improper and void because the Medicare Contractor lacked authority under Ruling 1498-R to make the findings that: (1) neither Samaritan nor Bergan met the jurisdictional requirements for a Board hearing based on their appeal of a revised NPR; and (2) as a result, neither met the requirements for remand under 1498-R. As such, these letters cannot be considered a final determination to which appeal rights to the Board attach. Rather this is a situation where the Medicare Contractor failed to follow a Board Remand Order issued pursuant to § 4.a of 1498-R and 42 C.F.R. § 405.1845(h). Accordingly, the Board hereby denies the Provider's request to form a new group appeal.

### *B. The Medicare Contractor Lacks Authority to Deny Jurisdiction for Samaritan and Bergan*

CMS issued Ruling 1498-R in April 2010 for three distinct issues, one of which was the inclusion of L&D days in the Medicaid fraction.[19] The Ruling takes jurisdiction over each

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[16] *Id.* at 6.
[17] *Id.* at 1.
[18] For any appeal filed with the Board, the Board must make jurisdictional findings pursuant to 42 C.F.R. § 405.1840. The alternative method bypasses Board review of jurisdiction under § 405.1840 by having the Medicare Contractor make jurisdictional findings in lieu of the Board. Accordingly, the alternative method is only applied *if and only if* the provider requests it. Similarly, apparently in recognition of § 405.1840, Ruling 1498-R specifies that, *under this alternative method*, if the Medicare contractor finds that the "claim does not meet all applicable jurisdictional and procedural requirements," a provider "may resume without prejudice its original appeal of the same claim before the same administrative appeals tribunal that previously remanded such claim to the contractor" and "[u]pon receipt of such a written notice from the provider, the appeals tribunal will then process the provider's original appeal of the same claim in accordance with the tribunal's usual, generally applicable appeal procedure." Ruing 1498-R at 20.
[19] Ruling 1498-R at 6.

properly pending claim of the three issues away from the Board *but only if* such claims otherwise have satisfied the applicable jurisdictional and procedural requirements for the appeal.[20] The Ruling creates two different methods to apply the Ruling – the standard/default method and the alternative method.

The first method is the "standard" or "default" method and is laid out in § 4.a of Ruling 1498-R entitled "The Standard Implementation Procedure." Section 4.a describes the standard/default method to apply the Ruling as follows:

> Under the standard or default implementation procedure, ***the administrative tribunal*** (*i.e.*, the PRRB, the Administrator of CMS, the fiscal intermediary hearing officer, or the CMS reviewing official) ***before which the appeal is pending*** will determine whether each claim at issue is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. ***If*** *the administrative tribunal* [***i.e., the Board in this case***] *finds that the applicable jurisdictional and procedural requirements are satisfied* for a given claim on one of the three DSH issues, *then the appeals tribunal will issue a brief written order, remanding each claim that qualifies for relief under the Ruling to the appropriate Medicare contractor for recalculation of the DSH payment adjustment* (in accordance with the instructions set forth below in Section 5 of this Ruling) for the period at issue.
>
> However, *if the administrative tribunal [**i.e., the Board in this case**] finds that* a given claim is outside the scope of the Ruling (because such claim is not for one of the three DSH issues) or *the claim fails to meet the applicable jurisdictional and procedural requirements for relief under the Ruling, then the appeals tribunal [**i.e., the Board in this case**] will issue a written order, briefly explaining why the tribunal found that such claim is not subject to the Ruling*. The appeals tribunal will then process the provider's original appeal of the same claim in accordance with the tribunal's usual, generally applicable appeal procedures.[21]

Thus, *for this case* under the standard/default method, the Board is the administrative tribunal charged with "determin[ing] whether each claim at issue is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines."[22]

In recognition of the volume of cases covered by Ruling 1498-R, CMS provided for an alternative method for remand in § 4.b of Ruling 1498-R entitled "The Alternative

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[20] *Id.*
[21] *Id.* at 17-18
[22] *Id.* at 17.

Implementation Procedure." Significantly, § 4.b of the Ruling 1498-R specifies that ***only*** the provider may initiate the alternative method:

> Under this alternative implementation procedure, ***the hospital*** in a single provider appeal ***may submit a*** *single written* ***request*** to the pertinent administrative tribunal, requesting a remand of each and every specific claim on any of the three DSH issues for qualifying patient discharge dates and cost reporting periods (as described above in Sections 1, 2, and 3 of this Ruling) that was raised in such appeal to the appropriate Medicare contractor for implementation of the Ruling, *without the administrative tribunal* ***first determining*** whether each of the provider's claims is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. On remand, under this alternative procedure, *the Medicare contractor would* ***then*** *assume the responsibility for determining whether each of the provider's claims is subject to the Ruling*.
>
> The same alternative implementation procedure is available for pending group appeals on one of the three DSH issues, *provided that* ***the group's designated representative*** ***submits a*** *single written* ***request***, on behalf of every provider and for every period at issue in the group appeal, to the administrative tribunal, requesting that the entire group appeal be remanded to the appropriate Medicare contractor for implementation of the Ruling; *here too, the Medicare contractor*, instead of the administrative appeals tribunal, *would* ***then*** *determine whether each claim in the group appeal is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines*. (However, if a provider in the group appeal were to submit a written objection to the group representative's prior request for a remand under this alternative implementation procedure, and the administrative tribunal received such written objection before it had issued a remand order under the alternative implementation procedure, then the tribunal will instead follow the standard implementation procedure (as described in Section 4.a. of this Ruling); as a result, the appeals tribunal would then determine whether each claim in the group appeal is for one of the three DSH issues and whether such claim satisfies all applicable jurisdictional and procedural requirements for relief under the Ruling.) [23]

Thus, ***if and only if*** a relevant provider or group representative specifically has requested in writing the alternative method may the Board deviate from the standard/default method and

[23] *Id*. at 18-19 (emphasis added.)

remand pursuant to the alternate method. Similarly, ***if and only if*** a provider or group representative has made a written request for the alternate method and the Board issues a remand under that method, may the relevant Medicare contractor follow the alternative procedure and "determin[e] whether each of the provider's claims is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines."[24]

In this case, the record confirms that Provider did ***not*** initiate the alternate remand with a written request. Accordingly, the Board properly applied the standard/default remand method to this case. As required by Ruling 1498-R and 42 C.F.R. § 1840, the Board made jurisdictional and procedural findings on each of the remaining 20 participants in Case No. 06-1198G, *including Samaritan and Bergan*, and found jurisdiction for all of them. Accordingly, the Board memorialized these jurisdictional finding in the 1498-R "Standard Remand" Order and remanded the 20 remaining participants in Case No. 06-1198G (including Samaritan and Bergan) "to the [Medicare Contractor" for recalculation of the Providers' DSH adjustment." Significantly, the Administrator did not exercise her discretion under 42 C.F.R. § 405.1875 to review the Board's final jurisdictional determination in Case No. 06-1198G.[25] Accordingly, the Board's jurisdictional determination became the Agency's final determination.

The Medicare Contractor apparently mistakenly believed that the alternative method was applicable to this case when it issued its January 13, 2016 letters essentially denying jurisdiction over Samaritan and Bergan by asserting that their respective appeals to the Board based on a revised NPR was not proper under 42 C.F.R. § 405.1887. However, as noted above, the alternative method clearly does not apply to this case. As such, the Medicare Contractor did not have the authority under Ruling 1498-R to make findings of jurisdiction over Samaritan and Bergan or, more importantly, to either ignore or overrule the Board's finding of jurisdiction in the Board's March 6, 2014 Remand Order.

Since the Board issued its Remand Order under the standard/default remand method, if the Medicare Contractor disagreed with the Board's finding of jurisdiction over Samaritan and Bergan, then the Medicare Contractor should have filed its jurisdictional challenge with the Board while the appeal was still pending with the Board pursuant to Board Rules 22 and 44.4

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[24] *Id*.

[25] A standard remand order under Ruling 1498-R is analogous to EJR decisions under 42 C.F.R. § 405.1875(a)(2)(3) where only the final jurisdictional decision would be reviewable by the Administrator. As such, a standard remand order would fall under § 405.1875(a)(2)(iv) and would be consistent with the example given in § 405.1875(b)(5). *See also* 42 C.F.R. § 405.1845(h)(3) (recognizing the Administrator's authority to review Board remand orders pursuant to § 405.1875(a)(2)(iv)). The Board recognizes that § 4.e of the Ruling addresses "Request for Review of a Finding That a Claim Is Not Subject to the Ruling" and that this section contains the statement: "Or, *if a Medicare fiscal intermediary* ***hearing officer*** *were to find,* ***under the standard implementation procedure*** (as set forth in § 4.a. of this Ruling), that a particular claim on one of the three DSH issues was not subject to the Ruling because the provider's appeal of such DSH claim did not meet a jurisdictional requirement (such as the requirement of timely filing of the provider's appeal), then the provider might request *the CMS reviewing official* to review the hearing officer's finding that the Ruling was inapplicable." CMS Ruling 1498-R at 26 (emphasis added). However, this statement is not applicable to this case because it involves a situation where the amount in controversy is less than $10,000 and the Medicare contractor *hearing officer* as part of a "contractor hearing" (*see* 42 C.F.R. §§ 405.1809 to 405.1834) is conducting the review under the alternative/default method and such "contractor hearings" are subject to review by a "CMS reviewing official" (*see* 42 C.F.R. § 405.1834).

(July 2009).[26] The Medicare Contractor had plenty of notice and opportunity in this case to do so. By letter dated November 16, 2010, the Provider submitted jurisdictional documents on Samaritan and Bergan addressing the revised NPR and related reopening on which their respective appeals were based. Further, by letter dated December 3, 2013, the Board informed the parties that the Board had initiated the 1498-R review of Case No. 06-1198 and specifically advised the Medicare Contractor that it needed to submit any comments on jurisdiction within 30 days. However, the Medicare Contractor failed to submit any comments or specifically respond to the jurisdictional documents that the Provider submitted. Further, even after the Board issued the March 6, 2014 Remand Order, the Medicare Contractor did not, to the Board's knowledge, request that the Administrator exercise its discretion to review the Board's finding of jurisdiction in that March 6, 2014 Remand Order.

Accordingly, ***the Board hereby orders the Medicare Contractor*** *to recalculate the DSH payment adjustment for the following two providers as mandated by the March 6, 2014 Board Order* pursuant the Board's authority under both the "standard or default implementation procedure" specified in § 4.a of Ruling 1498-R and 42 C.F.R. § 405.1845(h):

1. Good Samaritan Hospital, Provider No. 28-0009, FYE 6/30/2003; and
2. Bergan Mercy Medical Center, Provider No. 28-0060, FYE 6/30/3003.

*If the Medicare Contractor refuses or fails to implement the Board's March 6, 2014 Order as it relates to Samaritan and Bergan* ***within 30 days of the date of this letter (i.e., by September 6, 2019)***, the Providers may petition the Board for a referral of this matter to CMS pursuant to 42 C.F.R. § 405.1868(c).

Board Members Participating:

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

For the Board:

8/7/2019

X Clayton J. Nix

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

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

[26] Board Rule 22 states that, in group appeals, "[t]he lead Intermediary is responsible for reviewing the Schedule of Provider and the associated jurisdictional documentation" and "[t]he lead Intermediary must forward the final Schedule of Providers with the documentation to the Board to become part of the official record along with a cover letter verifying its position that the issue is suitable for appeal and whether jurisdictional impediments exist."

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
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RE: Sky Lakes Medical Center (Provider No. 38-0050, FYE 09/30/2009)
Case No. 13-2259

Dear Mr. Holden and Mr. Bloom,

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

**Background**

Sky Lakes Medical Center is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in an Original Notice of Program Reimbursement ("NPR") dated November 28, 2012 for fiscal year end ("FYE") 9/30/2009. The Provider timely filed an appeal from the NPR on May 30, 2013. The Model Form A-Individual Appeal Request presented initially presented one issue (SSI Provider Specific). On January 8, 2014, the Provider filed its Preliminary Position Paper, which included a second distinct issue: SSI Systemic Errors.

The Medicare Contractor submitted a jurisdictional challenge over the SSI Systemic Errors issue.

**Medicare Contractor's Contentions**

The Medicare Contractor argues that the Board does not have jurisdiction over the Issue 2 as identified in the Provider's Preliminary Position Paper, the SSI Systemic Errors issue, because it was not timely filed.[1] The contractor notes that a provider must submit its request to add an issue to the Board no later than 60 days after the expiration of the applicable 180-day period prescribed in 42 C.F.R. § 405.1835(a)(3)(i).[2] In the instant case, the Provider's deadline to add an issue would have been July 31, 2013.[3]

[1] The Medicare Administrative Contractor's Jurisdictional Challenge at 1.
[2] *Id*.
[3] *Id*.

The Medicare Contractor further argues that in its initial appeal request, the Provider only appealed one issue—Issue 1 SSI Provider Specific.[4] However, the Provider also included the SSI Systemic Errors issue in its Preliminary Position paper, which was submitted on January 8, 2014, and the Medicare Contractor has no record of the Provider formally adding this issue to its appeal. Therefore, the Medicare Contractor contends that the Provider did not timely add the issue.[5]

**Provider's Contentions**

The Provider did not submit a Jurisdictional Response.

**Board's Decision**

*SSI Provider Specific*

The Board finds that it has jurisdiction over a portion of the original issue in the appeal, the SSI Provider Specific issue. The jurisdictional analysis for this issue has two relevant components to consider: 1) the Provider disagreeing with how the Medicare contractor computed the SSI percentage used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The Provider's SSI Provider Specific issue questions "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[6] The Provider's legal basis argues that "it's [*sic*] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation." and that "the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed."[7] As this issue has not been transferred or directly added to another appeal and is not duplicative of an issue in another, the Board finds that it has jurisdiction over this component of the SSI Provider Specific issue.

The second component of the Provider Specific issue is the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. Pursuant to 42 C.F.R. §412.106(b)(3), when determining a provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the federal fiscal year, it must furnish to CMS, through its intermediary, a written request. . . ." Without the written request, the Medicare Contractor cannot issue a final determination that the provider can use to prove dissatisfaction during an appeal. Accordingly, the Board hereby dismisses the second component of the Provider Specific issue.

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[4] *Id*.
[5] *Id*.
[6] Provider's Individual Appeal Request.
[7] *Id*.

*SSI Systemic Errors*

The Board denies jurisdiction over Issue 2 (SSI Systemic Errors) as it was not timely added to the appeal. Effective August 21, 2008, Board regulations limit the addition of issues to appeals. 42 C.F.R. § 405.1835 provides in relevant part:

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

The Provider's NPR was issued on November 28, 2012, which makes the deadline for adding issues to its appeal July 26, 2013. The Provider attempted to add the SSI Systemic Errors issue to Case No. 13-2259 in its Preliminary Position Paper, which the Board received on January 8, 2014.

Additionally, Board Rule 23.3 states that, "Full development of the parties' positions fosters efficient use of the administrative review process and due process." Further, "Because the date for adding issues will have expired and transfers will be severely limited, the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position." Meaning that, the Provider is unable to introduce a new issue in its preliminary position paper as that inherently means that the period for adding issues has expired.

Furthermore, the Provider did not demonstrate that there was good cause to allow the addition of the issue. "Unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the documents), new arguments and documents not included in the preliminary position paper may be excluded at the hearing."

**Conclusion**

The Board finds that it does have jurisdiction over a portion of the SSI Provider Specific issue as it relates to the flawed calculation, but denies jurisdiction over SSI realignment as well as the second added issue of SSI Systemic Errors issue, as it was not timely added.

Case No. 13-2259 remains open as a portion of issue #1 remains pending in the appeal. A hearing is scheduled for November 21, 2019.

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

Board Members Participating:

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FOR THE BOARD

8/8/2019

X Clayton J. Nix

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Delivery**

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**RE:** ***EJR Determination***
15-2873G HLB Independent Hospitals 2012 DSH SSI Part C Days Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 17, 2019 request for expedited judicial review ("EJR") for the appeal referenced above.[1] The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this appeal is:

> [W]hether the Providers' DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[2]

**Statutory and Regulatory Background: Medicare DSH Payment**

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

[1] This EJR request also included case number 17-0437G. The Board will address the EJR request for that case under separate cover.
[2] Providers' EJR Request at 2.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*

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

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

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

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

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

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

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

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

> *part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.[12]

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[25] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] 72 Fed. Reg. at 47411.
[24] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F. 3d 1102 (D.C. Cir. 2014).

adopted in FFY 2005 IPPS rule.[26] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[28] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[29] Once again, the Secretary has not acquiesced to this decision.

**Providers' Request for EJR**

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

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

**Decision of the Board**

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

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[26] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[27] 863 F.3d 937 (D.C. Cir. 2017).
[28] *Id.* at 943.
[29] *Id.* at 943-945.

*Jurisdiction for the Group Participants*

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2012.

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

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

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

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

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.

A. Jurisdictional Determination On Certain Specific Individual Participants

At the outset, the Board notes that a Board finding of jurisdiction is a prerequisite to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority request "[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision,"[35] including documentation relating to jurisdiction. Similarly, the regulations governing group appeals specify that jurisdiction "may be raised at any time."[36]

Participant #4, Redland Community Hospital (Provider No. 05-0272, FYE 9/30/2012), appealed a revised NPR dated January 7, 2016 that adjusted DSH eligible days and not Part C days as required by 42 C.F.R. § 405.1889 for Board jurisdiction over a the Part C Days issue.

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

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

[35] 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which included a decision on both jurisdiction and the EJR request).

[36] 42 C.F.R. 405.1837(e)(2) states: "*The Board may make jurisdictional findings* under § 405.1840 ***at any time***, including, but not limited to, following a request by the providers for the jurisdictional findings. The providers may request jurisdictional findings by notifying the Board in writing that the group appeal is fully formed, or that the providers believe they have satisfied all of the requirements for a group appeal hearing request, and the Board may proceed to make jurisdictional findings."

The Board concludes that it lacks jurisdiction over Redlands Community Hospital's appeal of its revised NPR because the revised NPR that did not adjust the Part C days issue as required by 42 C.F.R. § 405.1889 and dismisses the Provider's appeal of its revised NPR from the case. Since jurisdiction over a provider is a perquisite to granting a request for EJR # 4 Redlands Community Hospital's request for EJR based on its revised NPR is hereby denied. The Board notes that the Provider's original NPR appeal remains pending in this case.

B. Jurisdictional Determination for Remaining Participants

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

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the 2012 cost reporting period. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[38] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[39] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
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FOR THE BOARD:

8/8/2019

X Clayton J. Nix

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

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

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**RE:** ***Jurisdictional Determination***
Northwest Medical Center (Provider No. 03-0085)
FYE 09/30/2013
PRRB Case No. 17-0206

Dear Mr. Summar and Mr. Lamprecht,

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

**Background**

Northwest Medical Center is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in an Original notice of Program Reimbursement ("NPR") dated April 27, 2016 for fiscal year end ("FYE") 9/30/2013. The Provider timely filed an appeal from the NPR on October 21, 2016. The Model Form A-Individual Appeal Request presented two issues:

1. Disproportionate Share Hospital Payment/ Supplemental Security Income Percentage (Provider Specific)
2. DSH—Medicaid Eligible Days

The Medicare Contractor submitted a jurisdictional challenge over the SSI Provider Specific issue.

**Medicare Contractor's Contentions**

The Medicare Contractor argues that the issue is suitable for reopening, but is not an appealable issue.[1] Further, the Medicare Contractor noted that the decision to realign a hospital's SSI percentage with its fiscal year is a hospital election, not a Medicare Contractor determination.[2] The hospital must make a formal request, through its Medicare Contractor, to the Center for

[1] Medicare Administrative contractor's Jurisdictional Challenge at 4.
[2] *Id*.

Medicare and Medicaid Services ("CMS") in order to receive a realigned SSI percentage.[3] Once the hospital chooses to use its own fiscal year end, it is bound by that decision, regardless of the reimbursement impact.[4]

In addition the Medicare Contractor contends that it cannot, and did not, make a determination in terms of the Provider's SSI percentage realignment. The Medicare contractor insists that the only party capable of making that determination is the provider. Because there is no Medicare Contractor determination to challenge, only the Provider's own choice, the Medicare Contractor insists that the Board has no jurisdiction over this issue.[5]

**Provider's Contentions**

The Provider contends that it "is not addressing a realignment of the SSI percentage, but that it is addressing the various errors of omission and commission that do not fit into the 'systemic errors' category."[6] Furthermore, the Provider argues that is an appealable item because the Medicare Contractor "specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for the fiscal year 2013 resulting from its understated SSI."[7]

In addition, the Provider states that it "is entitled to appeal an item with which it is dissatisfied."[8] The Provider uses the decision in *Northwest Hospital Corporation v. Sebelius* (D.C. Cir. September 13, 2011) to demonstrate that the Centers for Medicare and Medicaid Services "specifically abandoned the CMS Administrator's December 1, 2008 decision that the SSI ratio cannot be revised based on the updated data after it has been calculated by CMS."[9] Further, the Provider argues "that it can specifically identify patients believed to be entitle to both Medicare Part A and SSI who were not included in the Percentage determined by CMS."[10]

**Board's Decision**

As set forth below, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue.

The Provider's individual appeal is based on the contention that the SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients entitled to SSI benefits in the Provider's DSH calculation. This issue is duplicative of the SSI Systemic Errors issue that was directly added to Case No. 15-2694GC (Community Health Systems 2013 Post 1498R DSH SSI Data Match CIRP Group). The Providers in that CIRP Group challenge their SSI percentages because of disagreement over how the SSI percentage is calculated and contend that CMS has not properly computed the SSI percentage because it failed to include all patients

[3] *Id*.
[4] *Id*.
[5] *Id*.
[6] Provider's Jurisdictional Response at 1.
[7] *Id*.
[8] *Id*.
[9] *Id*.
[10] *Id*.

entitled to SSI benefits in the calculation. Pursuant to Board Rule 4.6.1, "A provider may not appeal an issue from a single determination in more than one appeal." Therefore, the Board finds that the SSI Provider specific issue is duplicative of the issue the Provider is appealing in the group appeal and hereby dismisses this aspect of the SSI Provider specific issue.

In its SSI Provider Specific issue statement, the Provider also asserts that it "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period." Under 42 C.F.R. § 412.106(b)(3), "if a hospital prefers that CMS use its cost reporting data instead of the Federal Fiscal Year, it must furnish to CMS, through its intermediary, a written request…" Without a written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for purposes of appeal. Additionally, even if the Provider has requested (and received) a realignment of its SSI percentage, that is not a final determination from which the Provider can appeal, or with which the Provider can be dissatisfied, as required by 42 C.F.R. § 405.1835(a). Therefore, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's SSI Provider Specific issue.

**Conclusion**

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative off the SSI Systemic Errors issue that was directly added to a group and because there is no final determination with respect to the realignment portion of the issue statement.

Case No. 17-0206 remains open as the Medicaid Eligible Days issue is still pending in this appeal. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

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

FOR THE BOARD:

8/8/2019

X Gregory H. Ziegler

Gregory H. Ziegler, CPA, CPC-A
Board Member
Signed by: Gregory H. Ziegler -S

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

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Provider Reimbursement Review Board
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410-786-2671

**Via Electronic Delivery**

Quality Reimbursement Services, Inc.
James Ravindran
President
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National Government Services, Inc.
Laurie Polson
Appeal Lead
MP: INA 102-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

**RE:** ***Jurisdictional Decision***
St. Luke's Hospital of Kansas City (Provider No. 26-0138)
FYE 12/31/2013
PRRB Case No. 17-0986

Dear Mr. Ravindran and Ms. Polson,

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

**Background**

St. Luke's Hospital of Kansas City is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in an Original Notice of Program Reimbursement ("NPR") dated August 24, 2016 for fiscal year end ("FYE") 12/31/2013. The Provider timely filed an appeal from the NPR on February 7, 2017. The Model Form A-Individual Appeal Request presented eight issues:

1. DSH/SSI (Provider Specific);
2. DSH/SSI (Systemic Errors);
3. DSH—SSI Fraction/Medicare Managed Part C Days;
4. DSH—SSI Fraction/ Dual Eligible Days
5. DSH—Medicaid Eligible Days
6. DSH—DSH Medicaid Fraction/ Medicare Managed Part C Days
7. DSH—Medicaid Fraction/Dual Eligible Days;
8. Outlier Payments (Fixed Loss Threshold)

The Board received several request to transfer issues to group appeal, including:

- Issue 2: SSI Systemic Errors issue, PRRB Case No. 17-2235GC
- Issue 3: SSI Fraction/Medicare Managed Part C Days issue, PRRB Case No. 17-2239GC
- Issue 4: SSI Fraction/ Dual Eligible Days, PRRB Case No. 17-2237GC
- Issue 6: Medicaid Fraction/ Medicare Managed Part C Days issue, PRRB Case No. 17-

2238GC.
- Issue 7: Medicaid Fraction/ Dual Eligible Days, PRRB Case No. 17-2236GC
- Issue 8: Outlier Payments (Fixed Loss Threshold), PRRB Case No. 17-2234GC

In the Provider's Preliminary Position Paper, it indicated that all issues other than the SSI Provider Specific and Medicaid Eligible Days issues had been transferred to group appeals. On June 21, 2019, The Board issued an Expedited Judicial Review ("EJR") in which it granted the Provider's request for EJR on the Medicare Days Part C issue.[1]

The Medicare Contractor submitted a jurisdictional challenge over the SSI Provider Specific issue.

**Medicare Contractor's Contentions**

The Medicare Contractor argues that the issue is suitable for reopening, but is not an appealable issue.[2] Further, the Medicare Contractor asserts that "[t]he decision to realign a hospitals SSI percentage with its fiscal year is a hospital election, not a MAC determination," and that the Medicare Contractor ". . . did not, and cannot, make a determination in terms of the provider's SSI percentage realignment."[3] There is no "MAC determination for the provider to contest, only the provider's own election, the PRRB does not have jurisdiction over this issue. . ."[4]

Additionally, the Medicare Contractor believes that Issue 1 (Provider Specific) is duplicative of its Issue 2 (Systemic Errors), which has been transferred to a group appeal.[5] The Medicare Contractor contends that the two issues are duplicative because they both concern SSI data.[6]

**Provider's Contentions**

The Provider argues that Issue 1 (SSI Provider Specific) is not a duplicative of Issue 2 (SSI Systemic Errors) because the two issues are "separate and distinct."[7] In support of its assertion, the Provider cites Board Rule 8.1 and claims that Appeal Issues 1 and 2 represent different components of the SSI issue.[8]

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[1] The request for EJR was initially submitted in Case Nos. 17-2238GC and 17-2239GC (the request included seven groups). These two groups included only one Provider, St. Luke's Hospital of Kansas City. Because these two groups did not meet the requirement for a group appeal, the Part C Days issue was transferred back to this individual appeal and the Board addressed the EJR request in this individual appeal.
[2] Medicare Administrative contractor's Jurisdictional Challenge at 4.
[3] *Id*.
[4] *Id*.
[5] *Id*. at 7.
[6] *Id*.
[7] Provider's Jurisdictional Response at 1.
[8] "Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must appealed as a separate issue and described as narrowly as possible. . ." Board Rule 8.1.

**Board's Decision**

As set forth below, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue.

The Provider's individual appeal is based on the contention that the SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients entitled to SSI benefits in the Provider's DSH calculation. This issue is duplicative of the SSI Systemic Errors issue that was transferred to Case No. 17-2235GC (QRS St. Luke's Health 2013 DSH SSI Percentage CIRP Group). The Providers in that CIRP Group challenge their SSI percentages because of disagreement over how the SSI percentage is calculated and contend that CMS has not properly computed the SSI percentage because it failed to include all patients entitled to SSI benefits in the calculation. Pursuant to Board Rule 4.6.1, "A provider may not appeal an issue from a single determination in more than one appeal." Therefore, the Board finds that the SSI Provider specific issue is duplicative of the issue the Provider is appealing in the group appeal and hereby dismisses this aspect of the SSI Provider specific issue.

In its SSI Provider Specific issue statement, the Provider also asserts that it "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period." Under 42 C.F.R. § 412.106(b)(3), "if a hospital prefers that CMS use its cost reporting data instead of the Federal Fiscal Year, it must furnish to CMS, through its intermediary, a written request…" Without a written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for purposes of appeal. Additionally, even if the Provider has requested (and received) a realignment of its SSI percentage, that is not a final determination from which the Provider can appeal, or with which the Provider can be dissatisfied, as required by 42 C.F.R. § 405.1835(a). Therefore, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's SSI Provider Specific issue.

**Conclusion**

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue directly added to a group and because there is no final determination with respect to the realignment portion of the issue.

Case No. 17-0206 remains open as the Medicaid Eligible Days issue is still pending in this appeal. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:
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Charlotte F. Benson, CPA
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Robert A. Evarts, Esq.
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FOR THE BOARD

8/8/2019

X Gregory H. Ziegler

Gregory H. Ziegler, CPA, CPC-A
Board Member
Signed by: Gregory H. Ziegler -S

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

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**Via Electronic Delivery**

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WPS Government Health Administrators
Byron Lamprecht, Cost Report Appeals
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Omaha, NE 68164

RE: Christian Hospital (Provider No. 26-0180, FYE 12/31/2013)
Case No. 17-1260

Dear Mr. Kramer and Ms. Lamprecht,

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

**Background**

Christian Hospital is appealing the amount of Medicare reimbursement as determined by its Medicare Contractor in an original Notice of Program Reimbursement ("NPR") dated October 10, 2016 for fiscal year end ("FYE") 12/31/2013. On March 17, 2017, the Provider requested to appeal directly from its final determination to Case No. 17-0834GC (QRS BJC 2013 DSH SSI Percentage CIRP Group). The Provider also timely filed an appeal from the NPR on March 20, 2017. The Model A-Individual Appeal Request presented two issues:

1. Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH")
2. Disproportionate Share Hospital—Medicaid Eligible Days

The Medicare Contractor submitted a jurisdictional challenge over both of these issues.

**Medicare Contractor's Contention**

*A. SSI Provider Specific*

The Medicare Contractor asserts that the Board does not have jurisdiction over Issue 1 because it is duplicative of an issue being pursued in the group appeal under Case No. 17-0834GC. The Medicare Contractor suggests that in the group case, ". . . the Provider contends that the Secretary improperly calculated its SSI percentage," which is the same argument it is making in the instant case.[1] Further, Medicare Contractor argues that the Provider is including a subsidiary

[1] Medicare Administrative Contractor's Jurisdictional Challenge at 2.

appeal over SSI Realignment.[2] It insists that the issue is "suitable for reopening, but is not an appealable issue." The Medicare Contractor asserts that ". . . the MAC did not, and cannot, make a determination in the terms of the provider's percentage realignment.[3]

*B. Medicaid Eligible Days*

The Medicare Contractor also argues that the Board does not have jurisdiction over Issue 2 because the Medicare Contractor did not adjust the disputed days, the Provider's appeal request cited five adjustments and claimed self-disallowance.[4] The Medicare Contractor notes that "[t]he evidence demonstrates that the provider has not appealed any of the days adjusted by the MAC. Amazingly, four of the audit adjustments cited by the provider are in no way related to Medicaid days."[5] In conclusion, the Medicare contractor asserts that the provider failed to provide any documenting evidence with its appeal under 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840.[6]

**Provider's Contentions**

*A. SSI Provider Specific*

The Provider argues that Issue 1 (SSI Provider Specific) is not a duplicate issue to Issue 2 (SSI Systemic Issue) that the Provider transferred to group appeal 17-0834GC (QRS BJC 2013 DSH SSI Percentage CIRP Group). Rather, the issues are "separate and distinct", and that the Board should fins that it has jurisdiction over them.[7] In support of its assertion, the Provider cites Board Rule 8.1 and claims that Appeal Issues 1 and 2 represent different components of the SSI issue.[8]

*B. Medicaid Eligible Days*

The Provider did not respond to the Medicare Contractor's jurisdictional challenge to this issue.

**Board's Decision**

*A. SSI Provider Specific*

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue. The jurisdictional analysis for this issue has two relevant aspects to consider: 1) the Provider disagreed with the Medicare Contractor's computation of the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

---

[2] *Id*.
[3] *Id*.
[4] *Id*. at 4.
[5] *Id*.
[6] *Id*. at 6.
[7] Provider Jurisdictional Response at 1.
[8] "Some issues may have multiple components. To comply with the regularity requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly ass possible. . ." Board Rule 8.1.

The Provider's disagreement with the Medicare Contractor's computation of the SSI percentage is duplicative of the Systemic Errors issue the Provider directly added to Case No. 17-0834GC. The Provider's DSH payment (Provider Specific) issue questions "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in Disproportionate Share Hospital ("DSH") calculation."[9] The Provider's legal basis argues that "it's [*sic*] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed CMS failed to include all patients that were entitled to SSI benefits in their calculation" and that "the SSI percentage issued by CMS and the subsequent audit information are both flawed"[10]

The Provider's SSI Systemic Errors issue ". . . contends that the Social Security Income ("SSI") percentage as generated by the Social Security Administration ("SSA") and put forth by the Centers for Medicare and Medicaid Services ("CMS") is understated.[11] Further, the Provider asserts that the understatement occurred due to a number of errors, including: 1) Errors in the matching process; 2) Treatment of Dual Eligible Days; and 3) Treatment of Medicare HMO/ Medicare Plus Choice Days.[12] Essentially, the Provider is simply arguing that its SSI percentage is inaccurate, which make this issue duplicative of the SSI Provider Specific issue in the instant case.

Because the SSI Systemic Errors issue was directly added to a group appeal, the Board hereby dismisses this aspect of the SSI Provider Specific issue from Case No. 17-1260.

The second aspect of the SSI System Errors issue addresses the Provider reserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "if a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request. . . ." Without this written request, the Medicare contractor cannot issue a final determination that the Provider can be dissatisfied with for appealing purposes. Accordingly, the Board hereby dismisses this aspect of the Provider Specific issue for lack of jurisdiction.

*B. Medicaid Eligible Days*

As set for the below, the Board finds that it has jurisdiction over the DSH Medicaid Eligible Days issue in this appeal.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

[9] Provider's Individual Appeal Request Tab 3, Issue 1.
[10] *Id*.
[11] Group Appeal Request for Case No. 17-0834GC.
[12] *Id*.

At issue in this jurisdictional dispute is the dissatisfaction requirement for Board jurisdiction. 42 C.F.R. 405.1835(a)(1)(2013) dictates that a provider must preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific items at issue, by either –

> (i) Including a claim for the specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy….

However, recent developments have limited the application of preservation/presentment requirement of 42 C.F.R. § 405.1835(a)(1).

In 2016, the D.C. federal district court held in *Banner Heart Hospital v. Burwell* ("*Banner*")[13] that a provider cannot be held to the claim preservation/presentment requirement of 42 C.F.R. § 405.1835(a)(1) when the provider is challenging a Medicare regulation or policy which the Medicare contractor has no authority to entertain or decide (such as a challenge to a Medicare regulation or policy). The *Banner* court explained its decision as follows:

> …when a provider fails to present a claim in its cost report that [a Medicare contractor] can address, it can be deemed "satisfied" with the amounts requested in the cost report and awarded by the [Medicare contractor]. But where the [Medicare contractor] has no authority to address a claim, such as when a pure legal challenge to a regulation is at issue, a provider cannot be deemed to be "satisfied" simply because such challenge is not reflected in the cost report. Satisfaction cannot be imputed from a provider's silence when everyone knows that it would be futile to present such claim to the [Medicare contractor].[14]

The *Banner* court looked to the Supreme Court's 1988 decision in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*")[15] which addressed a similar challenge to a regulation which was not first presented to the Medicare contractor. *Bethesda* holds that a provider need not protest self-disallowed costs that are barred from being claimed because of a specific statute, regulation, or ruling.[16] The Supreme Court in *Bethesda* stated:

> . . . [T]he submission of a cost report in full compliance with the

[13] 201 F. Supp. 3d 131 (D.D.C. 2016).
[14] *Id.* at 141.
[15] 485 U.S. 399 (1988).
[16] *Id.* at 404.

> unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the [Contractor]. Providers know that, under the statutory scheme, the [Contractor] is confined to the mere application of the Secretary's regulations, that the [Contractor] is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the [Contractor] to do otherwise would be futile.[17]

In response to the *Banner* decision, CMS issued Ruling CMS-1727-R ("Ruling 1727") to set forth its policy to create an exception to the application of the claim preservation/presentment requirement of 42 C.F.R. § 405.1835(a)(1) consistent with (but broader than) the holding in *Banner*. In this regard, Ruling 1727 sets out a five-step analysis for the Board to undertake to determine whether a provider is entitled to a Board hearing for an item that the provider appealed but did not include on its cost report. In short, a provider has a right to a Board hearing for such an item if it excluded the item based upon "a good faith belief that the item was subject to a payment regulation or other policy that gave the Medicare contractor no authority or discretion to make payment in the manner the provider sought."[18]

Analysis of the DSH Medicaid Eligible Days Under Ruling 1727

The first step of analysis under Ruling 1727 involves the appeal's filing date and cost reporting period. The appeal must have been pending or filed after the Ruling was issued on April 23, 2018. In the instant case, the Board received the Provider's request for hearing on March 20, 2017 and the appeal was open on April 23, 2018. Thus, it satisfies the appeal pending date requirement. Additionally, the Ruling applies to appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016. This appeal involves a fiscal year end December 31, 2013 cost report. Thus, the appealed cost reporting period falls within the required time frame.

Second, the Board must determine whether the appealed item "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider."[19]

Under §§ 1815(a) and 1833(e) of the Social Security Act, no Medicare payments are made to a provider unless the provider has furnished information requested by the Secretary so that the Secretary may determine the amount of payment due. With respect to a hospital's Medicare DSH payment—comprised of the Medicare and Medicaid DSH fractions—part of the Secretary's regulations mandate that a DSH-eligible hospital "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed…and of verifying with the

[17] *Id.*
[18] Ruling 1727 at unnumbered page 2.
[19] Ruling 1727 at 6.

State that a patient was eligible for Medicaid during each claimed patient hospital day."[20]

As the pertinent DSH regulations instruct that a provider is required to furnish Medicaid patient verification information to the Medicare contractor, and because the time frame within which a hospital must file its cost report is also set by regulation, the Board finds that the Provider's DSH Medicaid Eligible Days issue "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider." In other words, this issue meets the second requirement or step of Ruling 1727.

The third, fourth and fifth steps of analysis under Ruling 1727 involve the Board's assessment of whether a provider's appeal has met the jurisdictional requirements set out in the applicable regulation.[21] As the Provider's appeal was timely filed and the estimated amount in controversy is over $10,000, the first two Board jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, Ruling 1727 sets out three different scenarios—in steps three, four and five—for the Board to consider.

The Board looks to step three if it is reviewing an appealed item which was, in fact, within the payment authority or discretion of the Medicare contractor, *i.e.*, an "allowable" item. In the instant appeal, the DSH Medicaid Eligible Days sought are *not* within the payment authority or discretion of the Medicare Contractor because Provider could not prove or verify eligibility with the State in time to include the Days on the Provider's cost report, as required by regulation.

Under step four of Ruling 1727, the Board does not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable) if a determination has been made that the item under appeal was subject to a regulation or other policy that bound the Medicare Contractor and left it with no authority or discretion to make payment as sought. As discussed in step two above, these DSH Medicaid Eligible Days are "non-allowable" costs because the Medicare Contractor was bound by the proof of eligibility regulation at 42 C.F.R. § 412.106(b)(4)(iii), and thus the Board will "not apply the self-disallowance jurisdiction regulation" in this jurisdictional decision.

Under step five of Ruling 1727, the Board is directed to consider the circumstances surrounding a provider's self-disallowance claim. In the instant appeal, however, the Provider self-disallowed the Medicaid Eligible Days in its appeal request, in which it stated, "In addition to any Medicaid Eligible ("ME") days which were claimed in the cost report, there existed additional ME Days for which there existed practical impediments that prevented such days from being properly matched and verified according to applicable regulations required by the filing date."[22]

The Board finds that Christian Hospital's DSH Medicaid Eligible Days issue is within the Board's jurisdiction, based upon the *Banner* rationale and Ruling 1727-R, as it would have been futile to present DSH Medicaid Eligible Days to the Medicare Contractor without proof of

[20] 42 C.F.R. § 412.106(b)(4)(iii) (2010).
[21] 42 C.F.R. § 405.1835(a) (2010).
[22] Provider's Appeal Request at Tab 4.

eligibility and State verification.[23] The Board also finds that only those DSH Medicaid Eligible Days which were not able to be verified prior to the cost report filing date are subject to the Board's jurisdiction under *Banner* and Ruling 1727-R, and that the Provider and the Medicare Contractor shall, based on information privy to these two parties, ascertain the DSH Medicaid Eligible Days that are subject to the Board's jurisdiction.

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

FOR THE BOARD

8/8/2019

X Clayton J. Nix

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

cc: Wilson Leong, FSS

[23] For a thorough discussion of how the regulations bind and otherwise constrict providers and Medicare contractors in the reporting of Medicaid eligible days, *see* the Board's decision in *Barberton Citizens Hosp. v. CGS Adm'rs, LLC*, PRRB Dec. No. 2015-D5 (Mar. 19, 2015), *declined review*, CMS Adm'r (Apr. 22, 2015).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Mail**

Isaac Blumberg
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315 South Beverly Dr., Ste. 505
Beverly Hills, CA 90212-1925

**RE**: ***Expedited Judicial Review Determination***
19-1254GC SSM Health 2011 Medicare HMO Part C Days – Medicaid Fraction Group
19-1260GC SSM Health 2011 Medicare HMO Part C Days – Medicare Fraction Group

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 11, 2019 request for expedited judicial review ("EJR") (received July 16, 2019), for the above-referenced appeals. The Board's determination is set forth below.

**Issue in Dispute**

The issue in these appeals is:

> Whether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).[1]

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

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

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

> *part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period. (emphasis added)

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[10]

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[11] 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].[12]

[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services.
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[15]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare 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* . . . (emphasis added)[16]

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

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

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[13] *Id.*

[14] 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.

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[17] 69 Fed. Reg. at 49,099.

> *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.[18] (emphasis added)

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[19] 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).[20] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[21]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[22] 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

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[18] *Id.*
[19] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[20] 72 Fed. Reg. at 47411.
[21] 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).
[22] 746 F. 3d 1102 (D.C. Cir. 2014).

adopted in FFY 2005 IPPS rule.[23] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[24] 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*.[25] 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.[26] Once again, the Secretary has not acquiesced to this decision.

**Providers' Request for EJR**

The Providers assert that EJR is appropriate because the Secretary has not acquiesced to the decision in *Allina I*. As a result, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effective as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). The Providers point out that they have met the timely filing requirements and the amount in controversy and believe that EJR is appropriate since the Board is bound by the regulation.

**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.

Jurisdictional Determination

The participants in this EJR request have filed appeals involving fiscal year 2011.

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

[23] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[24] 863 F.3d 937 (D.C. Cir. 2017).
[25] *Id.* at 943.
[26] *Id.* at 943-945.

*Bowen* ("*Bethesda*").[27] 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.[28]

On August 21, 2008, new regulations governing the Board were effective.[29] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[30] 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.[31]

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 or after December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that jurisdiction over the participants involved with the instant EJR request is governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[32] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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[27] 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.).
[28] *Bethesda at 1258-59.*
[29] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[30] 201 F. Supp. 3d 131 (D.D.C. 2016)
[31] *Banner* at 142.
[32] *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the 2011 cost reporting period. Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[33] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[34] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.[35]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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[33] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

[34] *See* 42 U.S.C. § 1395oo(f)(1).

[35] Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in a number of cases identified in the EJR request. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina I*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since there are no other issues under dispute in these cases, the cases are hereby closed.

Board Members Participating:

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

FOR THE BOARD:

8/8/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators
Wilson Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: St. Rose Dominican Rose de Lima (Provider No. 29-0012)
FYE: 6/30/008
Case No. 13-2728

Dear Ms. Bhatnagar and Mr. Lowe,

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

## Background

The Provider submitted a request for hearing on August 13, 2013, based on a Notice of Program Reimbursement ("NPR") dated February 19, 2013. The hearing request included ten issues. The Provider added two issues to the appeal via a request dated September 12, 2013. Six issues have been transferred to group appeals. Five issues have been withdrawn. The sole remaining in the appeal is:

- Issue No. 2 – Medicare Disproportionate Share Hospital (DSH) Payments – Additional Medicaid Eligible Days

The Medicare Contractor submitted a jurisdictional challenge on this issue on June 10, 2014.[1] The Provider submitted a responsive brief on July 10, 2014.

## Medicare Contractor's Position

The Medicare Contractor explains that in Issue No. 2, the Provider is appealing the Medicaid ratio utilized in the calculation of the disproportionate share ("DSH") payment. The Medicare Contractor states that the Provider contends that its Medicaid ratio is understated due to the exclusion of 87 additional Medicaid eligible days. The Medicare Contractor contends that it did not render a final determination over the additional Medicaid days that the Provider seeks to include in the DSH Medicaid ratio. The Medicare Contactor contends that there was no adverse finding. Therefore, the Provider does not have the right to an appeal for this issue.[2]

[1] The Medicare Contractor also challenged three Medicare Low Income Patient (LIP) Payments issues which were subsequently withdrawn.
[2] Medicare Contractor's jurisdictional challenge at 1.

The Medicare Contractor explains that during its audit, the Medicare Contractor proposed Adjustment No. 7 to adjust the Title XIX days to the Medicaid Days listing. Adjustment No. 8 was proposed to add the labor and delivery days to the cost report. Neither of these adjustments rendered a determination with respect to additional Medicaid eligible days sought by the Provider. The implementation of Adjustments Nos. 7 and 8 resulted in decreasing the DSH Medicaid ratio from 12.33 to 11.54.[3]

The Medicare Contractor notes that the Provider filed its Medicare cost report identifying $222,337 of protested amounts. The Medicare Contractor removed this amount via Adjustment No. 44. According to the Provider's Summary of Protest Amounts, none of the $222,337 amount is related to the issue of 87 additional Medicaid eligible days for DSH. The Medicare Contractor contends that the Provider's dissatisfaction stems from its failure to claim the 87 additional days on its as-filed Medicare cost report. The Provider is dissatisfied with its own reporting of Medicaid days.[4]

The Medicare Contractor explains that the regulations at 42 C.F.R. § 405.1835 state in relevant part:

> (a) Criteria. The provider (but no other individual, entity, or party) has a right to a hearing before the Board about any matter designated in §405.1801(a)(1):
>
> (1) An intermediary determination has been made with respect to the provider; and
>
> (2) The provider has filed a written request for a hearing before the Board under the provisions described in §405.1841(a)(1); and
>
> (3) The amount in controversy (as determined in §405.1829(a)) is $10,000 or more

The regulations at 42 C.F.R. § 405.1841 state in relevant part:

> (a) General requirements
>
> (1) The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in § 405.1835(c). Such request for Board hearing *must identify the aspects of the determination with*

[3] Medicare Contractor's jurisdictional challenge at 2.
[4] Medicare Contractor's jurisdictional challenge at 2-3.

> *which the provider is dissatisfied*, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position (Emphasis added).

The Medicare Contractor also maintains that the regulations at 42 C.F.R. § 408.1835 limit the Provider's right to a hearing of the issues upon which it has made a final determination. In relevant part, this section states:

> The provider…has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if …[a]n intermediary determination has been made with respect to the provider.

The Medicare Contractor contends that the Provider failed to request reimbursement for all Medicaid days to which it was entitled under applicable rules. Moreover, referring to the Board's jurisdictional decision in *Danbury Hosp. v. Blue Cross Blue Shield Ass'n*,[5] the Provider makes no showing that, in connection with the Medicaid eligible days, it faced a practical impediment to which the *Bethesda* self-disallowance might attach. The Provider fails to establish that there was a practical impediment, through no fault of its own, preventing the Provider from identifying and/or verifying the additional days with the State prior to the filing of the cost report.[6]

The Medicare Contractor argues that in the instant case, the additional Medicaid days were omitted from the as-filed cost report. The Provider's dissatisfaction stems from its failure to claim the additional days. Logically, because the 87 additional days were not claimed by the Provider, the Medicare Contractor did not render a final determination over them or the associated reimbursement. Therefore, the Medicare Contractor requests that, consistent with its decision in *St. Vincent Hosp. & Med. Ctr. v. Blue Cross Blue Shield Ass'n*,[7] the Board exercise its discretion under 42 U.S.C. § 139500(d) and dismiss this issue.[8]

**Provider's Position**

The Provider contends that it has a properly pending appeal before the Board that meets all of the jurisdiction criteria set forth in 42 C.F.R. § 405.1835(a) and (b). Specifically, in accordance with 42 C.F.R. § 405.1835(a)(1)(i), there can be no dispute about the fact the Provider preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) (*i.e.*, Medicaid eligible days) at issue by including a claim for Medicaid eligible days on its cost report. The Medicare Contractor adjusted the Provider's reported Medicaid eligible days which created Provider dissatisfaction with the NPR issued by the Medicare Contractor. The Medicare

[5] PRRB Dec. No. 2014-D03 (Feb. 11, 2014), declined review, CMS Adm'r (Mar. 26, 2014).
[6] Medicare Contractor's jurisdictional challenge at 5.
[7] PRRB Dec. No. 2013-D39 (Sept. 13, 2013), *declined review*, CMS Adm'r (Oct. 25, 2013).
[8] Medicare Contractor's jurisdictional challenge at 6.

Contractor rationalizes dissatisfaction can only reside with the audit adjustment that was implemented. In contrast, the Provider contends that dissatisfaction is created by the Medicare Contractor when they examine an item in a filed cost report and implement a change that does not result in a correct amount. In short, the Medicare Contractor argues that the Provider cannot be dissatisfied in instances when the Medicare Contractor implements a positive adjustment, however, the Provider counters that a positive adjustment does not necessarily equate to a correct adjustment.[9]

The Provider argues that a review of the Provider's appeal request is warranted. The Provider states that it made specific reference to Medicaid eligible days verified by the State of Nevada within their appeal dispute. Furthermore, the Provider cited in their appeal letter audit adjustments 7 and 8 as being in dispute. The Provider contends that the Medicare Contractor, in its jurisdictional challenge, did not submit evidence showing that the Medicare Contractor incorporated *all days presented by the Provider*. The Provider contends that the additional Medicaid eligible days sought by the Provider for inclusion into the DSH payment calculation were presented to the Medicare Contractor during the audit process and were dismissed. The Provider states that, nevertheless, it has preserved its appeal right on this issue through an adjustment to the amounts filed.[10]

In addressing this issue in its final position paper dated June 4, 2019, the Provider states that it is important to understand there is a lag between the time the State can process "final" Medicaid eligibility (13 months after the fiscal year end) and the filing of the Medicare cost reports (5 months after the fiscal year end). The Provider argues that the State of Nevada is unable to verify *final* Medicaid eligibility for purposes of incorporating such data into the filed Medicare cost report. CMS regulation 42 C.F.R. § 412.106(b)(4)(iii) requires Medicaid eligible days be verified by the State for purposes of calculating proper DSH payments. This CMS regulation requirement conflicts with the State of Nevada's policy of processing Medicaid eligibility at least 13 months after the Provider's fiscal year end. The Provider is left in a position of vulnerability and has no recourse other than appealing the inconsistency between the CMS regulation, which assumes Medicaid eligibility will be performed before the cost report is filed, and the State of Nevada's internal policy of processing Medicaid eligibility at least 13 months after the Provider's fiscal year end.[11]

[9] Provider's jurisdictional response at 2.
[10] Provider's jurisdictional response at 3.
[11] Provider's Final Position Paper at 5-6. The Board observes that the Provider also argues that the Medicare Contractor understated the Provider's SSI ratio. The Board notes, however, that Issue No. 8 – Accuracy of CMS Developed SSI Ratio Issued March 16, 2012 was previously transferred to PRRB Case No. 13-3799GC – Dignity Health 2008 Accuracy of CMS Developed SSI Ratio Issued 3/16/12 on March 25, 2014.

**Board's Decision**

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§ 405.1835 – 1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that CMS Ruling 1727-R does not apply in this appeal as this is a 6/30/08 FYE and it does not fall into the time frame laid out in the Ruling (12/31/2008 cost reports and after).

The Board finds that, pursuant to the rationale in *Barberton Citizens Hosp. vs. CGS Administrators,* PRRB Dec. No. 2015-D5 (March 19, 2015)("*Barberton")*, St. Rose Dominican Rose de Lima was able to establish that there was a practical impediment to capturing every Medicaid eligible day by the deadline for filing its cost report. In *Barberton*, the Board states "pursuant to the concept of futility in *Bethesda*, the Board has jurisdiction of a hospital's appeal of additional Medicaid eligible days for the DSH adjustment calculation if that hospital can establish a "practical impediment" as to why it could not claim these days at the time that it filed its cost report."[12] As noted in its final position paper, St. Rose Dominican Rose de Lima states that the additional eligible days could not be verified at the time the cost report was filed due to the State of Nevada's policy of not processing final Medicaid eligibility until 13 months after the fiscal year end.

In the instant appeal, the Provider's cost reporting period ended June 30, 2008. Thus, the Provider was not subject to the Protest requirement that was effective for cost report periods ending on or after December 31, 2008. As St. Rose Dominican Rose de Lima established that a practical impediment, through no fault of its own, prevented it from identifying and/or verifying the Medicaid Eligible Days prior to the filing of its cost report, the Board concludes that it has jurisdiction over this issue.

Additionally, the Board notes that, in its Final Position Paper, St. Rose Dominican Rose de Lima purports to discuss the only remaining issues in dispute. However, within its discussion of the Medicaid Eligible Days issue, it also refers to the understatement of SSI ratio issue. The Board notes that the understatement of the issue was previously transferred to a group appeal and, as such, does not currently reside in the individual appeal.

[12] *Barberton* at 4.

*This case is scheduled for a live hearing on September 6, 2019.* Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:

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For the Board:

8/8/2019

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RE: St. Rose Dominican Rose de Lima (Provider No.: 29-0012)
FYE 6/30/09
Case No. 13-2729

Dear Ms. Bhatnagar and Mr. Lowe,

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

## Background

The Provider submitted a request for hearing on August 13, 2013, based on a Notice of Program Reimbursement ("NPR") dated February 22, 2013. The hearing request included eleven issues. The Provider added two issues to the appeal via a request dated September 12, 2013. Six issues have been transferred to group appeals. Five issues have been withdrawn. Two issues remain in the appeal as follows:

- Issue No. 2 – Medicare Bad Debt
- Issue No. 3 – Medicare Disproportionate Share Hospital ("DSH") Payments – Additional Medicaid Eligible Days

The Medicare Contractor submitted a jurisdictional challenge on Issue No. 3 on June 25, 2014.[1] The Provider submitted a responsive brief on July 23, 2014.

## Medicare Contractor's Position

The Medicare Contractor explains that, in Issue No. 3, the Provider is appealing the Medicaid ratio utilized in the calculation of the DSH payment. The Medicare Contractor states that the Provider contends that its Medicaid ratio is understated due to the exclusion of 99 additional Medicaid eligible days. The Medicare Contractor contends that it did not render a final determination over the additional Medicaid days that the Provider seeks to include in the DSH

[1] The Medicare Contractor also challenged six additional issues. Four issues were subsequently withdrawn and two issues were transferred to group appeals. With respect to the transferred issues, the challenge will be addressed in the group appeals.

Medicaid ratio. The Medicare Contactor contends that there was no adverse finding. Therefore, the Provider does not have the right to an appeal for this issue.[2]

The Medicare Contractor explains that, during its audit, the Medicare Contractor proposed Adjustment No. 11 to include days based on the revised DSH listing submitted by the Provider. Adjustment No. 12 was proposed to adjust the Medicaid days due to a footing error where days were omitted. Neither of these adjustments rendered a determination with respect to the additional Medicaid eligible days sought by the Provider. The implementation of Adjustments Nos. 11 and 12 resulted in increasing the DSH Medicaid ratio from 13.79 to 14.59.[3]

The Medicare Contractor notes that the Provider filed its Medicare cost report identifying $216,235 of protested amounts. The Medicare Contractor removed this amount via Adjustment No. 34. According to the Provider's Summary of Protest Amounts, none of the $216,235 amount is related to the issue of 99 additional Medicaid eligible days for DSH. The Medicare Contractor contends that the Provider's dissatisfaction stems from its failure to claim the 99 additional days on its as-filed Medicare cost report. The Provider is dissatisfied with its own reporting of Medicaid days.[4]

The Medicare Contractor explains that the regulations at 42 C.F.R. § 405.1835 state in relevant part:

> (a) Criteria. The provider (but no other individual, entity, or party) has a right to a hearing before the Board about any matter designated in §405.1801(a)(1):
>
> (1) An intermediary determination has been made with respect to the provider; and
>
> (2) The provider has filed a written request for a hearing before the Board under the provisions described in §405.1841(a)(1); and
>
> (3) The amount in controversy (as determined in §405.1829(a)) is $10,000 or more

The regulations at 42 C.F.R. § 405.1841 state in relevant part:

> (a) General requirements
>
> (1) The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in § 405.1835(c).

[2] Medicare Contractor's jurisdictional challenge at 1.
[3] Medicare Contractor's jurisdictional challenge at 3.
[4] Medicare Contractor's jurisdictional challenge at 3.

> Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position (Emphasis added).

The Medicare Contractor also maintains that the regulations at 42 C.F.R. § 408.1835 limit the Provider's right to a hearing of the issues upon which it has made a final determination. In relevant part, this section states:

> The provider…has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if …[a]n intermediary determination has been made with respect to the provider.

The Medicare Contractor contends that the Provider failed to request reimbursement for all Medicaid days to which it was entitled under applicable rules. Moreover, referring to the Board's jurisdictional decision in *Danbury Hospital v. BlueCross BlueShield Ass'n*,[5] the Provider makes no showing that, in connection with the Medicaid eligible days, it faced a practical impediment to which the *Bethesda* self-disallowance might attach. The Provider fails to establish that there was a practical impediment, through no fault of its own, preventing the Provider from identifying and/or verifying the additional days with the State prior to the filing of the cost report.[6]

The Medicare Contractor argues that, in the instant case, the additional Medicaid days were omitted from the as-filed cost report. The Provider's dissatisfaction stems from its failure to claim the additional days. Logically, because the additional days were not claimed by the Provider, the Medicare Contractor did not render a final determination over them or the associated reimbursement. Therefore, the Medicare Contractor requests that, consistent with its decision in *St. Vincent Hosp. & Med. Ctr. v. Blue Cross Blue Shield Ass'n*,[7] the Board exercise its discretion under 42 U.S.C. § 139500(d) and dismiss this issue.[8]

**Provider's Position**

The Provider contends that it has a properly pending appeal before the Board that meets all of the jurisdiction criteria set forth in 42 C.F.R. § 405.1835(a) and (b). Specifically, in accordance with 42 C.F.R. § 405.1835(a)(1)(i) there can be no dispute about the fact the Provider preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) (*i.e.*, Medicaid eligible days) at issue by including a claim for Medicaid eligible days on its cost report. The Medicare Contractor adjusted the Provider's reported Medicaid eligible days which created Provider dissatisfaction with the NPR issued by the Medicare Contractor. The Medicare Contractor rationalizes dissatisfaction can only reside with the audit adjustment that was implemented. In contrast, the Provider contends that dissatisfaction is created by the Medicare

[5] PRRB Dec. No. 2014-D03 (Feb. 11, 2014), declined review, CMS Adm'r (Mar. 26, 2014).
[6] Medicare Contractor's jurisdictional challenge at 5.
[7] PRRB Dec. No. 2013-D39 (Sept. 13, 2013), *declined review*, CMS Adm'r (Oct. 25, 2013).
[8] Medicare Contractor's jurisdictional challenge at 6.

Contractor when they examine an item in a filed cost report and implement a change that does not result in a correct amount. In short, the Medicare Contractor argues that the Provider cannot be dissatisfied in instances when the Medicare Contractor implements a positive adjustment, however, the Provider counters that a positive adjustment does not necessarily equate to a correct adjustment.[9]

The Provider argues that a review of the Provider's appeal request is warranted. The Provider states that it made specific reference to Medicaid eligible days verified by the State of Nevada within their appeal dispute. Furthermore, the Provider cited in their appeal letter Audit Adjustments Nos. 11 and 12 as being in dispute. The Provider contends that the Medicare Contractor, in its jurisdictional challenge, did not submit evidence showing that the Medicare Contractor incorporated *all days presented by the Provider*. The Provider contends that the additional Medicaid eligible days sought by the Provider for inclusion into the DSH payment calculation were presented to the Medicare Contractor during the audit process and were dismissed. The Provider states that, nevertheless, it has preserved its appeal right on this issue through an adjustment to the amounts filed.[10]

In addressing this issue in its final position paper dated June 4, 2019, the Provider states that it is important to understand there is a lag between the time the State can process "final" Medicaid eligibility (13 months after the fiscal year end) and the filing of the Medicare cost reports (5 months after the fiscal year end). The Provider argues that the State of Nevada is unable to verify *final* Medicaid eligibility for purposes of incorporating such data into the filed Medicare cost report. CMS regulation 42 C.F.R. § 412.106(b)(4)(iii) requires Medicaid eligible days be verified by the State for purposes of calculating proper DSH payments. This CMS regulation requirement conflicts with the State of Nevada's policy of processing Medicaid eligibility at least 13 months after the Provider's fiscal year end. The Provider is left in a position of vulnerability and has no recourse other than appealing the inconsistency between the CMS regulation, which assumes Medicaid eligibility will be performed before the cost report is filed, and the State of Nevada's internal policy of processing Medicaid eligibility at least 13 months after the Provider's fiscal year end.[11]

## Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider

[9] Provider's jurisdictional response at 2-3.
[10] Provider's jurisdictional response at 3.
[11] Provider's Final Position Paper at 10. The Board observes that the Provider also argues that the Medicare Contractor understated the Provider's SSI ratio. The Board notes, however, that Issue No. 9 – Accuracy of CMS Developed SSI Ratio Issued March 16, 2012 was previously transferred to PRRB Case No. 14-2797GC – Dignity Health 2009 Accuracy of CMS Developed SSI Ratio Issued 3/16/12 CIRP Group on March 25, 2014.

has preserved its right to claim dissatisfaction…..by…..[i]ncluding a claim for specific item(s) on its cost report…or…self-disallowing the specific item(s) by…..filing a cost report under protest…..[12]

The Provider is appealing from a 6/30/2009 cost report, which per the regulation means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction. Although St. Rose Dominican Rose de Lima does not appear to have claimed or protested the Medicaid eligible days in this appeal, the Board must also look to CMS Ruling "CMS-1727-R" to determine whether it has jurisdiction to hear St. Rose Dominican's Medicaid eligible days issue.

CMS-1727-R sets out a five-step analysis for the Board to undertake in order to determine whether a provider is entitled to a Board hearing for an item that the provider appealed but did not include on its cost report. In short, a provider has a right to a Board hearing for such an item if it excluded the item based upon "a good faith belief that the item was subject to a payment regulation or other policy that gave the Medicare contractor no authority or discretion to make payment in the manner the provider sought." [13] A provider's Board appeal pending or filed on or after April 23, 2018, that concerns a cost reporting period ending on or after December 31, 2008, and beginning before January 1, 2016, is subject to the five-step analysis set out in CMS-1727-R.

The first step in the analysis involves the appeal's filing date and cost reporting period. On August 13, 2013, the Board received Marian's Request for Hearing concerning its FYE 6/30/09cost reporting period, thus mandates set out in the Ruling apply to St. Rose Dominican's instant appeal.

Second, the Board must determine whether the appealed item "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider."[14]

Under Sections 1851(a) and 1833(e) of the Social Security Act, no Medicare payments are made to a provider unless the provider has furnished information requested by the Secretary so that the Secretary may determine the amount of payment due. With respect to a hospital's Medicare DSH payment-comprised of the Medicare and Medicaid fractions-part of the Secretary's regulations mandate that a DSH-eligible hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[15]

In the instant appeal, St. Rose Dominican argues that it was unable to include all of its Medicaid eligible days on its cost report because the documentation to verify all of the days was not available at the time that St. Rose Dominican was required to submit its information.[16] St. Rose Dominican states that the State of Nevada does not process Medicaid eligibility until 13 months

[12] 42 C.F.R. § 405.1835(a).
[13] CMS-1727-R at unnumbered page 2.
[14] CMS-1727-R at unnumbered page 6.
[15] 42 C.F.R. § 412.106(b)(4)(iii) (2010).
[16] Provider's jurisdictional response at 16.

after the fiscal year end. The cost report is due prior to that and therefore only estimated days can be included on the cost report, and the number will never be accurate and complete due to missing information.

As the pertinent DSH regulations instruct that a provider is required to furnish Medicaid patient verification information to the Medicare contractor, and because the time frame within which a hospital must file its cost report is also set by regulation, the Board finds that St. Rose Dominican's Medicaid eligible days issue "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider." In other words, St. Rose Dominican's issue meets the requirements of the second step in CMS-1727-R.

The third, fourth and fifth steps in CMS-1727-R's analysis involves the Board's assessment of whether a provider's appeal has met the jurisdictional requirements set out in the applicable regulation.[17] As St. Rose Dominican's appeal was timely filed and St. Rose Dominican estimates that its amount in controversy is over $10,000, the first two Board jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, CMS-1727-R sets out three different scenarios-in steps three, four and five-for the Board to consider.

The Board looks to step three if it is reviewing an appealed item which was, in fact, within the payment authority or discretion of the Medicare contractor, i.e., an "allowable" item. In the instant appeal, St. Rose Dominican's Medicaid eligible days were not within the payment authority or discretion of the Medicare contractor because St. Rose Dominican had not verified the days at the time that it filed its cost report, as explained above.

The Board looks to step four if it is reviewing an appealed item that was deemed "non-allowable." Under the Board's jurisdictional regulation, a provider who seeks payment that it believes is not in accordance with Medicare policy, i.e.,, a non-allowable item, must self-disallow the item by filing its cost report under protest. However, under CMS-1727-R, if the Board finds that the appealed item was subject to a regulation or other payment policy that bound the Medicare contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, then the Board shall not apply the self-disallowance jurisdictional regulation. In the instant appeal, under the analysis for CMS-1727-R's step two, St. Rose Dominican's appealed Medicaid eligible days appear to be subject to a regulation that bound the Medicare contractor such that it had no discretion or authority to make payment as sought by St. Rose Dominican. Therefore, under the terms of CMS-1727-R, the Board "shall not apply the self-disallowance jurisdiction regulation" to St. Rose Dominican's Medicaid eligible days issue when considering whether the issue meets the "dissatisfaction" jurisdictional requirement of 42 C.F.R. 405.1835(a).

Under CMS-1727-R's fifth step, the Board may still consider the circumstances surrounding a provider's self-disallowance claim. In the instant appeal, however, St. Rose Dominican did not self-disallow its Medicaid eligible days issue, thus this step is not applicable to this appeal.

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[17] 42 C.F.R. § 405.1835(a) (2010).

*In summary*, despite the fact that St. Rose Dominican did not claim or protest its appealed Medicaid eligible days, based on the five-step analysis set out in CMS-1727-R, the Board concludes that to the extent that St. Rose Dominican's Medicaid eligible days under appeal were not able to be verified prior to the cost report filing date, the Board has jurisdiction under CMS-1727-R. Without the actual listing of days being requested, and the specific information related to those days, the Board cannot verify that each and every day was verified after the cost report was submitted, but to the extent that they were, the Provider was barred from claiming those days on the as-filed cost report for payment. It is the responsibility of both St. Rose Dominican and the Medicare Contractor, based on information privy to these two parties, to ascertain the Medicaid eligible days that are subject to the Board's jurisdiction.

Additionally, the Board notes that, in its Final Position Paper, St. Rose Dominican Rose de Lima purports to discuss the only remaining issues in dispute. However, within its discussion of the Medicaid Eligible Days issue, it also refers to the understatement of SSI ratio issue. The Board notes that the understatement of the issue was previously transferred to a group appeal and, as such, does not currently reside in the individual appeal.

*This case is scheduled for a live hearing on September 6, 2019*. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

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**RE:** ***Jurisdictional Challenge***
Lakeview Specialty Hospital & Rehab Center (Provider No. 52-2005)
FYE: 12/31/2012
Case No. 18-1659

Dear Mr. Marcin and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in Case No. 18-1659. The Board hereby determines that it lacks jurisdiction over the appeal. Accordingly, the Board closes Case No. 18-1659 and removes it from the Board's docket.

## Background

Lakeview Specialty Hospital & Rehab Center's ("Lakeview" or "Provider") filed an appeal request September 13, 2018, related to a "Notice of Closure" dated June 27, 2018. The Notice of Closure related to a Notice of Reopening previously issued on January 8, 2016.[1] The Provider's appeal request contained the following issue statement:

*"Corrections to Material Errors that Resulted in an Outlier Reconciliation"*

The Medicare administrative contractor ("MAC") contends that the Board does not have jurisdiction over this appeal. On January 8, 2016, the MAC issued a Notice of Reopening. However, on June 27, 2018, the MAC issued the Notice of Closure of June 27, 2018 closing the January 8, 2016 Notice of Reopening. "The MAC considered the merits of the reopening request and determined that the materiality threshold would not be met thus, closed the Reopening was closed" without modifications to the cost report.[2]

The MAC contends that the June 27, 2018 closure without revision of a revised Notice of Program Reimbursement ("NPR") is not an appealable determination under 42 C.F.R. § 405.1887(d).[3] The Provider appealed from the Notice of Closure stating, "The Provider is appealing the MACs determination that the corrections to material errors and resulting

[1] MAC's Jurisdictional Challenge (Jan 2, 2019).
[2] *Id.* at 1.
[3] *Id.*

reimbursement impact are immaterial…". The MAC contends the closure of a reopening without revisions is not appealable under 42 C.F.R. § 405.1887(d) which states:

> A reopening by itself does not extend appeal rights. Any matter that is reconsidered during the course of a reopening, but is not revised, is not within the proper scope of an appeal of a revised determination or decision.

Pursuant to 42 C.F.R. § 405.1885(c), jurisdiction for reopening a determination or decision rests exclusively with the administrative body that rendered the last determination or decision.[4] In this case, the MAC rendered the last determination when it issued the original Notice of Program Reimbursement.

The Provider argues that the MAC did reopen the Provider's FYE 12/31/2012 cost report on or about January 8, 2016, when it issued the reopening notice.[5] Further, the Provider asserts that, subsequent to issuing the reopening notice, the MAC issued two (2) "preliminary reports" by which it accepted certain of Provider's proposed corrections.[6] Thereafter, on or about June 27, 2018, the MAC issued a Notice of Closure of its reopening, with scant explanation: "Unfortunately, due to immateriality the reopening is being closed."[7]

**Board Determination**

42 C.F.R. § 405.1885(a)(5) reads, "[i]f a matter is reopened and a revised determination or decision is made, a revised determination or decision is appealable to the extent provided in §405.1889 of this subpart."[8] Here, the Provider claims the reopening notice is tantamount to the matter being "reopened," regardless of whether the MAC subsequently decided that the Provider's proposed corrections to its cost report were immaterial.

The MAC refers to 42 C.F.R. § 405.1887(d) which, as noted above, states that a reopening that does not revise any matter is not within the proper scope of an appeal of a revised determination or decision. While the MAC seemingly accepted a number of proposed changes in that the MAC issued two (2) "*preliminary* reports" by which it seemingly was proposing to accept certain of Provider's proposed corrections,[9] the MAC ultimately determined as memorialized in its June 27, 2018 notice that the Provider's proposed adjustments did not meet the materiality threshold

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[4] *See Your Home Visiting Nurse Servs, Inc. v. Shalala*, 525 U.S. 449 (1999).
[5] Provider's Response to MAC's Jurisdictional Challenge (Feb. 1, 2019).
[6] *See* Provider's Jurisdictional Response at Exhibits C, D (copies of the "preliminary reports").
[7] *Id.*
[8] (Emphasis added.)
[9] The Provider includes copies of what the Provider describes (and hence concedes) are "*preliminary* reports" at Exhibits C and D to the Provider Jurisdictional Response. (Emphasis added.) The Board also recognizes that the MAC concedes that it "considered the merits of the reopening request." MAC's Jurisdictional Challenge at 1. However, it is unclear in what context the MAC issued those so-called "preliminary reports." They are dated roughly a year apart with one dated April 3, 2017 and the other dated April 19, 2018 and the Provider did not include any cover letter or email from the MAC. The MAC closed the reopening on June 27, 2018. Thus, in viewing these documents in their most favorable light, the Board can only ascribe any adjustments included therein as "preliminary" (*i.e.*, not final) *at best*.

without addressing the merits. Accordingly, the MAC closed the Reopening was closed without a revised NPR or final determination being issued. While the MAC did issue a Notice of Reopening and did to some extent "consider[] the merits of the reopening request,"[10] it is clear that they closed the reopening without a revised determination.

The dispute is whether the MACs Notice of Reopening, review of the data, and subsequent denial of reopening and refusal to issue a revised NPR meets the requirements to have a valid appeal based on the following language from 42 C.F.R. § 405.1885(a)(5): "If a matter is reopened ***and*** a revised determination or decision is made, a revised determination or decision is appealable to the extent provided in §405.1889 of this subpart."[11] Here, the MAC reopened the cost report and appears to have issued "preliminary" adjustments.[12] However, it is clear that the MAC *never* finalized any adjustments by issuing a revised NPR. Rather, the MAC closed the reopening due to its finding of immateriality without addressing the merits. Therefore, because both a reopening ***and*** a revised final determination did not occur, there can be no appeal rights. The preamble to the May 23, 2008 final rule[13] that promulgated the above regulation supports the Board's finding:

> As courts have noted, the reopening procedures are strictly a creature of the Secretary's regulations, and are not required, or specifically authorized, by statute. See *HCA Health Servs. of Oklahoma* v. *Shalala*, 27 F.3d 614, 618 (D.C. Cir. 1994) and *Albert Einstein Med. Ctr.* v. *Sullivan*, 830 F. Supp. 846, 851 (E.D. Pa. 1992), *aff'd* 6 F.3d 778 (3d Cir. 1993). . . . In designing the reopening procedures, we have chosen, as is our prerogative, to extend appeal rights only to those matters **actually revised following a reopening**. . . . [T]he issue is what a provider should be allowed to appeal. The statute gives a provider the right to appeal matters covered by an initial intermediary determination if the amount in controversy requirement is met and the provider timely requests a Board hearing. If the provider does not pursue its statutory appeal right with respect to a certain item, it loses its right to appeal that item. That right may be resuscitated **if that item is actually revised <u>in a revised determination</u>**, because, under our longstanding policy, **the revised determination** is considered a separate and distinct determination to which the intermediary and Board appeals procedures (including the amount in controversy and timely request for hearing requirements) apply. If an item is not actually revised, however, there is no need to extend appeal rights to that matter simply because it was mentioned in a notice of reopening. Courts that rejected providers' arguments that the issuance of a revised determination subjected the entire cost report to appeal did so on the basis that the statutory deadline for appealing

[10] *See* MAC's Jurisdictional Challenge at 1. This is not unusual as MACs often issue the Notice of Reopening prior to auditing any data. It starts the clock for them to review the data and preserves the three-year reopening right of the provider.
[11] (Emphasis added.)
[12] *See supra* note 9.
[13] 73 Fed. Reg. 30190 (May 23, 2008).

> matters would be defeated. (See *Anaheim Mem. Hosp.* v. *Shalala*, 130 F.23 845, 852 (9th Cir. 1997) and *HCA Health Services of Oklahoma* v. *Shalala*, 27 F.3d at 620–21 (and cases cited therein)). If we were to allow an appeal of a matter that is addressed in a notice of reopening but not actually revised, there similarly would be a frustration of the statutory deadline for appealing. A matter that is addressed in a reopening, but not revised, remains just as administratively final as an item not addressed in a notice of reopening.[14]

Moreover, as confirmed by the Supreme Court's decision in *Your Home*,[15] a MAC has the discretion whether to reopen a cost report and the provider neither has a right to reopening nor a right to appeal from a MAC's denial of a reopening. Therefore, it follows that a Provider cannot appeal a MAC's decision to close a reopening without revising the original NPR.

Accordingly, the Board hereby denies jurisdiction in Case No. 18-1659 and hereby closes this case. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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For the Board:

8/8/2019

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

[14] 73 Fed. Reg. at 30231 (bold and underline emphasis added).
[15] *Your Home Visiting Nurse Servs, Inc. v. Shalala*, 525 U.S. 449 (1999).

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**Via Electronic Delivery**

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**RE:** ***Expedited Judicial Review Determination***
14-2530G HLB Independent Hospitals 2010 DSH SSI Part C Days Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 19, 2019 request for expedited judicial review ("EJR") for the appeal referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this appeal is:

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

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Providers' Request for EJR**

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

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

**Decision of the Board**

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

Jurisdiction

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

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

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

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

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

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

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

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

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

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for

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

judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

8/9/2019

X Clayton J. Nix

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

Enclosures: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Mail**

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**RE:** ***Jurisdictional Decision***
Memorial Hospital (Provider No. 14-0185)
FYE 12/31/2007
Case No. 13-3048

Dear Mr. Ravindran and Ms. Hartley,

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

**Pertinent Facts:**

Memorial Hospital ("Memorial") appealed its original NPR for the FYE 12/31/2007 cost reporting period and included nine issues with that appeal. Memorial requested transfer of a number of issues to various group appeals. Similarly, Memorial withdrew its Medicaid Eligible Labor Room Days issue by letter dated April 29, 2014. As a result of the requests for transfer and the withdrawal, only 4 issues remain pending in Case No. 13-3048 —

1. DSH/SSI Provider Specific,
2. Medicaid eligible days,
3. Crossover Bad Debts and
4. Charity Care Bad Debts.

In its Preliminary Position Paper, the Provider briefed these four remaining issues as well as an additional issue involving Bad Debts at a collection agency.[1]

On August 26, 2014, the Medicare Contractor submitted a Jurisdictional Challenge. First, the Medicare Contractor challenges "Issue 10" (Bad Debts at collection agency) included in Memorial's Preliminary Position Paper.[2] The Medicare Contractor contends that this issue was

[1] Memorial's Preliminary Position Paper (Apr. 30, 2014)(Note: Provider withdrew the Labor Room issue on cover page); Medicare Contractor's Jurisdictional Challenge at I-2.
[2] Jurisdictional Challenge at 1-2

not included in the original appeal request and was added past the deadline to add issues to the appeal.[3]

Second, the Medicare Contractor challenges Issues 8 (Crossover Bad Debts) and 9 (Charity Care Bad Debts), arguing that Memorial is attempting to add unclaimed Bad Debts. The Medicare Contractor states it has not received a listing of these Bad Debts and that, therefore, no adjustment was made as required for Board jurisdiction.[4]

In its Jurisdictional Response submitted September 19, 2014, Memorial requests that its "collection agency bad debt issue be withdrawn . . . ."[5] Further, Memorial argued that the Board has jurisdiction over its Medicare Crossover and Charity Care Bad Debt issues.[6] Memorial argues that there are valid adjustments to Bad Debts, which is enough to warrant Board jurisdiction and specifically cites to Audit Adjustment Nos. 26 and 29.[7] Alternatively, Memorial contends that an adjustment is not required for bad debts because the "presentment requirement" is not valid.[8] In support of this contention, Memorial references the Supreme Court's holding in *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988).[9]

Finally, Memorial argued that the Medicare program assumed the responsibility to roll over Crossover Bad Debts claims it receives to the respective State Agency for secondary billing. However, Memorial recognized that not all of these bad debts may have been "crossing over"[10] and, in this regard, contended that it could not claim the additional bad debts with its original cost report submission.[11] Specifically, Memorial contended that it could not timely identify the additional Charity Care Bad Debts because it was unable to determine indigent Medicare beneficiaries prior to filing its cost report.[12]

Subsequent to filing its Jurisdictional Response, by letter dated July 11, 2019, the Provider "request[ed] that the Medicare Crossover Bad Debts and Medicare Charity Care Bad Debts issues be withdrawn from individual appeal PRRB Case Number 13-3048."

Finally, by letter dated July 5, 2019, Memorial argues that the DSH/SSI Provider Specific Issue is different from the DSH/SSI Systemic Issue that it transferred to Case No. 13-3931G. Memorial asserts that "the SSI Systemic issue addresses various errors discussed in Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008) in CMS' calculation of the disproportionate payment percentage, which result in the MedPAR not reflecting all individuals who are eligible for SSI . . ." In that letter, Memorial asserts that the DSH/SSI Systemic issue

[3] *Id*. at 2.
[4] *Id*. at 2.
[5] Memorial's Jurisdictional Response at 1 (Sep. 17, 2014).
[6] Memorial's Jurisdictional Response at 1 (Sep. 17, 2014).
[7] *Id*.
[8] *Id*. at 2-4.
[9] *Id*. at 4.
[10] *Id*.
[11] *Id*.
[12] *Id*.

"also covers CMS Ruling 1498-R." In contrast, Memorial asserts in that letter that, for the DSH/SSI Provider Specific issue, it "is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category." In this regard, Memorial further asserts that it "has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Parts A and SSI and that it "has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio." Memorial, without explaining the basis for its belief, then concludes that it "has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the Baystate litigation."

**Board Decision:**

A provider is entitled to a hearing before the Board if: (1) such provider is dissatisfied with a final determination of the Medicare Contractor as to its amount of total program reimbursement due the provider; (2) the amount in controversy is $10,000 or more; and, (3) such provider files a request for a hearing within 180 days after notice of the final determination.[13] The Board should find that Memorial timely filed its appeal and meets the amount in controversy requirement. The jurisdictional issues presented here is whether Memorial preserved its right to claim dissatisfaction with a final determination. In this case, the Medicare Contractor argues that the Provider was required to claim or protest the payment in order to be entitled to a Board hearing.

*A. Bad Debts at a Collection Agency, Crossover Bad Debts, and Charity Care Bad Debts.*

Memorial has withdrawn each of these three (3) issues from Case No. 13-3048. Accordingly, these three (3) issue are no longer part of Case No. 13-3048 and the Medicare Contractor's jurisdictional challenges to them are now moot.

*B. DSH/SSI Provider Specific*

As set forth below, the Board is dismissing the DSH/SSI Provider Specific issue because it is duplicative of the DSH/SSI Systemic Errors issue. Within the discussion of the DSH/SSI Provider Specific issue, Memorial's appeal request included an additional issue— the DSH/SSI Realignment issue. As set forth below, the Board is also dismissing the DSH/SSI Realignment issue because it is was not appealed base on a final determination and, thus, is premature.

For the DSH/SSI Provider Specific issue, Memorial argues that it disagrees with the Medicare Contractor's computation of its SSI percentage. As explained *in its appeal request* ***filed on August 29, 2013***, Memorial's legal basis for the DSH/SSI Provider Specific issue is that "its'

[13] 42 U.S.C. § 1395oo(a).

[*sic*] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patient that were entitled to SSI benefits in their calculation" and, as a result, "[Memorial] is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[14] In the section of its *Final Position Paper* discussing this issue, Memorial essentially restates this basis and cites to *Baystate* in support:

> The Provider Contends that its' [*sic*] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31). . . .
>
> Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' [*sic*] records with that of CMS, and identify patients believed to be entitled to both meidcare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

The group to which Memorial requested transfer of the DSH/SSI Systemic issue (Case No. 13-2679G) appealed this very same issue. The Board notes that the group appeal requested dated July 18, 2013 contested, among other things, the availability of MEDPAR and SSA records to "permit the Provider[s] to . . . reconcile the SSI data maintained by [SSA]." The Providers in the group maintain their "need[] to perform a review of the [MEDPAR] data to determine if there are any missing records." The appeal request also cites *Baystate* and notes certain fundamental problems in the calculation of the SSI percentage.

In its letter dated July 5, 2019, Memorial asserts that the DSH/SSI Provider Specific and DSH/SSI Systemic issues can be differentiated because the DSH/SSI Systemic issue essentially addresses "errors which result from CMS' improper data matching process" while the DSH/SSI Provider Specific Issue addresses "the various errors of *omission* ***and*** *commission* that do not fit into the 'systemic errors' category."[15] In support of this differentiation, Memorial asserts that it "has ***specifically identified*** patients *believed* to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the Baystate litigation."[16] However, Memorial fails to provide any basis for the beliefs and assertions made in those statements. For example, Memorial fails to explain how any of the alleged patients it has "specifically identified" were (or even may have been) otherwise omitted from their SSI percentage or how those errors are (or may be) an "error[] of omission or commission that do[es] not fit into the "systemic errors' category." In summary, Memorial does

[14] Memorial's Appeal Request at Tab 3, Issue 1; Medicare Contractor Jurisdictional Challenge for Bad Debts at I-2.
[15] (Emphasis added.)
[16] (Emphasis added.)

not give any basis for its conclusory statements notwithstanding the facts that: (1) it has had more than ample opportunity to do so (it has had approximately six (6) years to look at this issue since filing this appeal in August 2013); and (2) it should have already done so as part of its Final Position Paper (filed August 22, 2018, roughly 5 years after the appeal request was filed) because Board Rule 27.2 (2013) requires each party to thoroughly explain their positions in its final position paper.

Accordingly, the Board finds that the DSH/SSI Provider Specific issue is duplicative of the DSH/SSI Systemic issue for which the Provider requested transfer to Case No. 13-3931G. Therefore, the Board dismisses the DSH/SSI Provider Specific issue from Case No. 13-3048.

Memorial also requested the right to preserve an appeal to its DSH/SSI Realignment.[17] Under 42 C.F.R. § 412.106(b)(3), "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its [Medicare Contractor], a written request . . . ." Pursuant to 42 C.F.R. § 405.1835(a)(1), a provider must appeal from a final determination. However, without a written request, the Medicare Contractor cannot issue a final determination regarding DSH/SSI Realignment. Accordingly, the Board dismisses the DSH/SSI Realignment issue from Case No. 13-3931 because there can be no valid appeal of an issue without there first being a final determination on that issue.

* * * * *

Case No. 13-3048 remains open as there remains one issue concerning Medicaid eligible days. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

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X Clayton J. Nix

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Chair
Signed by: Clayton J. Nix -A

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

[17] *Id*.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Via Electronic Delivery**

Community Health Systems, Inc.
Mr. Nathan Summar
Vice President Revenue Management
4000 Meridian Boulevard
Franklin, TN 37067

WPS Government Health Administrators
Mr. Byron Lamprecht
Supervisor - Cost Report Appeals
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: Seven Rivers Regional Medical Center (Provider No. 10-0249)
FYE 05/31/2014
Case No. 17-0058

Dear Messrs. Summar and Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in case number 17-0058. The jurisdictional decision of the Board is set forth below.

**Background:**

Seven Rivers Regional Medical is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in an Original Notice of Program Reimbursement ("NPR") for fiscal year end ("FYE") May 31, 2014. The Provider timely filed an appeal from the NPR on October 11, 2016. The Model Form A- Individual Appeal Request presented eleven issues:

1. DSH Payment Supplemental Security income SSI Percentage (Provider Specific)
2. DSH /SSI Systemic Errors
3. DSH SSI Fraction/ Medicare Managed Care Part C Days
4. DSH SSI Fraction/ Dual Eligible Days
5. DSH Medicaid Fraction/ Medicare Managed Care Part C Days
6. DSH Medicaid Fraction/ Dual Eligible Days
7. DSH Medicaid Eligible Days
8. DSH Medicare Managed Care Part C Days
9. DSH Dual Eligible Days
10. Uncompensated Care Distribution Pool ("UCC")
11. 2 Midnight Census IPPS Payment Reduction ("IPPS")

On May 16, 2017, the Provider submitted its Preliminary Position Paper and indicated that it was transferring all issues to various group appeals except for Issue 1 (the SSI Provider Specific issue) and Issue 7 (the Medicaid Eligible Days issue). In particular, the Provider transferred Issue 2 (the SSI Systemic issue) to Case No. 17-0578GC – QRS HMA 2014 DSH SSI Percentage CIRP Group.

On April 26, 2018, the Medicare Contractor submitted a jurisdictional challenge. On May 29, 2018, the Provider submitted its Jurisdictional Response.

**Medicare Contractor's Contentions:**

The Medicare Contractor challenged jurisdiction over five issues: SSI Provider Specific (including SSI Realignment), SSI Systemic Errors, Medicare Managed Care Part C Days, Dual Eligible Days, Duplicate Issues - SSI Provider Specific, SSI Systemic Errors Issue and UCC.

*SSI Provider Specific and SSI Realignment issues*

The Medicare Contractor argues that the Board does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue and that the Provider is improperly appealing SSI percentage under separate issues.[1] The Medicare Contractor points out that both issues reference the same audit adjustment numbers namely 5, 7, 9, S-D.[2] The Medicare Contractor further contends that the SSI data is the underlying issue for both DSH - Systemic Errors and DSH- SSI percentage Provider Specific issues.[3]

Further, the Medicare Contractor contends that the SSI Realignment issue is suitable for reopening, but not appealable.[4] The Medicare Contractor explains that in the context of an SSI realignment request, it has not made a final determination with which a Provider could be dissatisfied, therefore the Board does not have jurisdiction pursuant to 42 C.F.R. § 405.1835. The Medicare Contractor concludes that the Provider cannot appeal the realignment of its SSI percentage or try to leverage its appeal regarding the validity of the SSI percentage by including the realignment as an appeal issue.[5]

*Medicare Managed Care Part C Days*

The Medicare Contractor argues that the Provider has already bifurcated the Medicare Managed Care Part C Days issue into two separate and distinct issues; Medicare Managed Care Part C

[1] *Id* at 8.
[2] *Id.*
[3] *Id.*
[4] Medicare Contractor's Jurisdictional Challenge at 4.
[5] *Id.* at 5.

Days within the SSI Fraction and the Medicare Managed Care Part C days within the Medicaid Fraction.[6] The Medicare Contractor reasons that these fractions are added together and expressed as the DSH percentage and that, therefore, the Provider's inclusion of the general Medicare Managed Care Part C Days issue is redundant.[7]

*Uncompensated Care*

The Medicare Contractor challenged jurisdiction over the UCC issue. However, on May 15, 2017, the Provider transferred this issue to the group appeal under Case No. 17-0573GC and, on December 11, 2018, the Board denied jurisdiction over group issue. Accordingly, the Board need not address this jurisdictional challenge as it is now moot.

**Provider's Contentions:**

*SSI Provider Specific and SSI Realignment Issues*

The Provider contends that the each of the appealed SSI issues are separate and distinct.[8] Further, the Provider argues that the issues represent different components of the SSI issue, which were specifically adjusted during the audit.[9] Further, the Provider asserts that in *Northeast Hospital Corporation v. Sebelius*, the Centers for Medicare and Medicaid Services ("CMS") abandoned the CMS Administrator's December 1, 2008 decision. 657 F.3d 1 (D.C. Cir. 2011).[10] The decision abandoned was that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS.[11] Thus, the Provider reasons that it can submit data to prove its SSI percentage was understated.

The Provider further contends that the Medicare Contractor is incorrect in arguing that the DSH/SSI realignment issue is not an appealable issue.[12] The Provider states that it is addressing the realignment of the SSI percentage, but also "various errors of omission and commission" that do not fit into the "systemic errors" category.[13] Therefore, the Provider argues that this is an appealable issue because the Medicare Contractor specifically adjusted its SSI percentage and the Provider is dissatisfied with the amount of DSH payments received for FYE as a result of its understated SSI percentage.[14]

[6] *Id*. at 6
[7] *Id.*
[8] *Id.* at 1.
[9] *Id*.
[10] *Id.*
[11] *Id.*
[12] Provider's Jurisdictional Response at 2.
[13] *Id.*
[14] *Id.*

*Medicare Part C and Dual Eligible Days Duplicate Issues*

The Provider agrees that there are duplicate issues and requests that Issue 5 be consolidated with Issue 8 and that Issue 6 be consolidated with Issue 9.[15]

**Board's Decision:**

*SSI Provider Specific and Realignment Issues*

As set forth below, the Board finds that the SSI Provider Specific issue is a duplicate issue and that it does not have jurisdiction over the SSI Realignment issue. Accordingly, the Board dismisses both issues.

Per its appeal request, the Provider's individual appeal is based the SSI Provider Specific issue on the contention that "its' [*sic*] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation" and, as a result, "[t]he Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage." Finally, in connection with its contention that the SSI percentage is flawed:

> The Provider contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI bud did not receive an SSI payment"

In contrast, per its appeal request, the Provider based its SSI Systemic issue on its contention that "the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed" and that these SSI percentages "fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute. The Provider then restates the same above-quoted "entitled" contention (word for word). Finally, the Providers as part of the SSI Systemic issue contend that they are "seeking resolution of the following aspects of the Medicare fraction that were not addressed in the Baystate case" including "Availability of MEDPAR and SSA Records," "Fundamental problems

[15] *Id.* at 6-7.

in the SSI percentage calculation," and "not in agreement with provider's records." The group appeal to which the Provider transferred the SSI Systemic issue (Case No. 17-0578GC) contains word for word virtually the exact same group issue statement in its appeal request filed November 28, 2016.

Pursuant to Board Rule 4.6.1, "A provider may not appeal an issue from a single determination in more than one appeal." Accordingly, the Board finds that the SSI Provider specific issue is duplicative of the SSI Systemic issue the Provider is appealing in the group appeal and hereby dismisses this aspect of the SSI Provider specific issue.

In the remaining portion of its SSI Provider Specific issue statement, the Provider asserts that it "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period." Under 42 C.F.R. § 412.106(b)(3), "if a hospital prefers that CMS use its cost reporting data instead of the Federal Fiscal Year, it must furnish to CMS, through its intermediary, a written request…" Without a written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for purposes of appeal. Additionally, even if the Provider has requested (and received) a realignment of its SSI percentage, that is not a final determination from which the Provider can appeal, or with which the Provider can be dissatisfied, as required by 42 C.F.R. § 405.1835(a). Therefore, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's SSI Provider Specific issue.

*Medicare Part C and Dual Eligible Days Duplicate Issues*

The Board agrees with the parties that Issue 8, Medicare Managed Care Part C Days, and Issue 9, Dual Eligible Days, are duplicative of the same issues that the Provider separately appealed for the Medicaid and SSI Fractions, and that have since been transferred to group appeals. Therefore, the Board hereby consolidates the Medicare Managed Care Days issue with the Medicaid and SSI fraction issues that were transferred to Case Nos. 17-0574GC and 17-0576GC, respectively. Similarly, the Board hereby consolidates the Dual Eligible Days issue with the Medicaid and SSI fraction issues that were transferred to Case Nos. 17-0577GC and 17-0575GC, respectively. The Medicare Managed Care Part C Days and Dual Eligible Days issues are no longer pending in this individual appeal.

**Conclusion:**

The Board dismisses the SSI Provider Specific issue in its entirety because it is duplicative of the SSI Systemic errors issue that was transferred to a group and there is no final determination with respect to the realignment portion of the issue.

The Board consolidates the Medicare Managed Care Part C Days and Dual Eligible Days issue into the Medicaid and SSI fraction issues that were transferred to group appeals.

The Medicare Contractor challenged jurisdiction over the UCC issue, however this issue was transferred to group appeal on May 15, 2017 Case No. 17-0573GC. As the Board denied jurisdiction over group issue on December 11, 2018, the Board need not address the jurisdictional challenge in this individual appeal.

The Medicaid eligible days issue is the sole remaining issue that remains pending in this appeal. A 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.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

8/9/2019

X Clayton J. Nix

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

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

James Ravindran
Quality Reimbursement Services
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RE: **EJR Determination**
17-0568GC QRS WVUHS 2013 DSH Medicaid Fraction Medicare Part C Days Group
17-0571GC QRS WVUHS 2013 DSH SSI Fraction Medicare Part C Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 19, 2019 request for expedited judicial review ("EJR") and the July 18, 2019 response to the Board's July 9, 2019 request for additional information[1] for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.[2]

[1] The period under appeal in these cases involved the period 1/1/2013 through 12/31/2013 which spans Federal fiscal years 2013 and 2014. The period prior to 10/01/2013 is governed by FFY 2005 Part C Days SSI Policy which was published in the August 11, 2004 Federal Register and specified that Part Medicare Part C days would be counted in the SSI fraction of the DSH calculation for discharges on or after October 31, 2004 (codified at 42 C.F.R. §§ 405.106(b)(2)(i)(B) and (b)(2)(iii)(B)). Following the decision in *Allina Healthcare Services v. Sebelius*, 904 F. Supp. 2d 75, *aff'd in part and rev. in part*, 746 F.3d 1102 (D.C. Cir. 2014), the Secretary readopted the regulation codifying the FFY 2005 Part C Days Policy in the August 19, 2013 Federal Register without any changes. This readoption was effective for discharges occurring on or after October 1, 2013. The Board asked the Providers to confirm whether they appealed only the FFY 2005 Part C Days SSI Policy or if they were also appealing the FFY 2014 readopted regulation as well. The Providers indicated that they were challenging only the 2005 Part C Days Policy, but requested that the Part C days occurring after 10/1/2013 be bifurcated into a separate group appeals. The Board bifurcated the cases, as requested. Case No. 17-0571GC was bifurcated and the period on or after 10/01/2013 was placed in Case No. 19-2368GC and Case No. 17-0568GC was bifurcated and the period on or after 10/01/2013 was placed in Case No. 19-2376GC.

[2] Providers' EJR request at 1.

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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[16] *Id.*

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

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

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

[20] 69 Fed. Reg. at 49099.

> *stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[21]

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[25] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[26] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare

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

fraction had been vacated in *Allina I*.[28] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[29] Once again, the Secretary has not acquiesced to this decision.

**Providers' Request for EJR**

The Providers explain that "[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The '2004 Rule') The Board is bound by the 2004 rule."[30] Accordingly, the Providers contend that the Board should grant their request for EJR.

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

**Decision of the Board**

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 1/1/2013 through 9/30/2013.

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

[28] *Id.* at 943.
[29] *Id.* at 943-945.
[30] Providers' EJR Request at 1.
[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

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.

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling 1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[36] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned 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.

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Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

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

[33] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

[34] 201 F. Supp. 3d 131 (D.D.C. 2016).

[35] *Id.* at 142.

[36] *See* 42 C.F.R. § 405.1837.

*Board's Analysis Regarding the Appealed Issue*

The appeals in these EJR request involve the 1/1/2013 through 9/30/2013 cost reporting period.[37] Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[38] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[39] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request. [40]

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year[41] and that the participants in these group appeals are entitled to a hearing before the Board;

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

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

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

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

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[37] *See supra* note 1.
[38] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[39] *See* 42 U.S.C. § 1395oo(f)(1).
[40] One of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in a number of cases identified in the EJR request. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.
[41] *See supra* note 1.

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

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

FOR THE BOARD:

8/14/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Laurie Polson, Palmetto GBA c/o National Government Services
Wilson Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Electronic Delivery**

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RE: **EJR Determination**
13-2748G HLB Independent Hospitals 2008 DSH SSI Part C Days Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 19, 2019 request for expedited judicial review ("EJR") for the appeal referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this appeal is:

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

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Providers' Request for EJR**

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

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

**Decision of the Board**

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

Jurisdiction

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

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

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

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

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

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

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

*Board's Decision Regarding Jurisdiction and EJR*

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R.[34] In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[35] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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[34] The Medicare Contractor file a jurisdictional challenged on March 2, 2015, arguing that the Board lacks jurisdiction over a number of participants in this group appeal because they failed to claim Part C days on their cost reports as a protested amount as required by 42 C.F.R. § 405.1835(a)(1)(ii). This jurisdictional challenge is now moot as the result of the Secretary's issuance of CMS Ruling CMS-1727-R, which was effective April 23, 2018.
[35] *See* 42 C.F.R. § 405.1837.
[36] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[37] *See* 42 U.S.C. § 1395oo(f)(1).

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

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

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

Board Members Participating:

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

FOR THE BOARD:

8/15/2019

X Clayton J. Nix

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

Enclosures: Schedule of Providers

cc: Lorraine Frewert, Noridian Health Care Solutions c/o Cahaba Safeguard Administrators (Electronic Mail w/Schedule of Providers)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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**RE: *EJR Determination***
15-1550GC SWC CHE 2012 DSH SSI Fraction Part C Days Group

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 19, 2019 request for expedited judicial review ("EJR")[1] (received July 21, 2019) and July 24, 2019 resubmission of the Schedule of Providers and associated jurisdiction documents in response to the Board's July 17, 2019 request, for the appeal referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this appeal is:

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

**Statutory and Regulatory Background: Medicare DSH Payment**

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

[1] This EJR request also included case numbers 16-0425GC, 16-1821GC, 16-1822GC 16-2041GC and 17-0093GC. A response to the Providers' EJR request in those cases was sent under separate cover.
[2] Providers' EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[20] 69 Fed. Reg. at 49099.

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

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

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

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

**Providers' Request for EJR**

The Providers explain that "[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed

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

from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The '2004 Rule') The Board is bound by the 2004 rule."[30] Accordingly, the Providers contend that the Board should grant their request for EJR.

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

**Decision of the Board**

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

Jurisdiction

The participants that comprise a group appeal within this EJR request have filed appeals involving fiscal year 2012.

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

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

[30] Providers' EJR Request at 1.
[31] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[32] *Bethesda at 1258-59.*
[33] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

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.

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[36] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

*A. Jurisdictional Determination: Appeals of Revised NPRs and the SSI Realignment*

# 7 Rancocas Hospital (Provider No. 31-0061), #11 St. Peter's Hospital (Provider No. 33-0057) and #15 Mercy Suburban Hospital (Provider No. 39-0116) appealed their revised NPRs that did not adjust the Part C issue as required for Board jurisdiction. Rather the appeals are based on adjustments made as the result of SSI realignments. Each of these Providers requested "a recalculation of the Medicare SSI ratio. . . . based on the provider's cost report period (01/1/2012 through 12/31/2012) be used rather than the data based on the [F]ederal fiscal year" in accordance with the regulation 42 C.F.R. § 405.106(b)(3). Through the Providers' respective Notices of Reopening, the Medicare Contractor agreed to reopen the cost reports "to review the DSH payment calculation for the realigned SSI [adjustment] based on the cost reporting period."[37] The SSI adjustments identified as the subject of the disputes in this case reflect implementation of the SSI ratio realignment completed by the Medicare Contractor.

The regulation, 42 C.F.R. § 412.106(b)(3), permits a provider to request to have its data reported on its cost reporting period instead of the Federal fiscal year. To do so, "It must

[34] 201 F. Supp. 3d 131 (D.D.C. 2016)
[35] *Banner* at 142.
[36] See 42 C.F.R. § 405.1889(b)(1) (2008).
[37] *See* the July 24, 2019 Jurisdictional Documents, Tab 7.A., 11.A. and 15.A.

furnish to CMS, through its Intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period."

#7 Rancocas Hospital (Provider No. 31-0061), #11 St. Peter's Hospital (Provider No. 33-0057) and #15 Mercy Suburban Hospital (Provider No. 39-0116) requested that their SSI percentages be recalculated from the federal fiscal year to their respective cost reporting years. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used.[38] The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the September 30 FFY.

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

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

Since the revised NPRs for #7 Rancocas Hospital (Provider No. 31-0061), #11 St. Peter's Hospital (Provider No. 33-0057) and #15 Mercy Suburban Hospital (Provider No. 39-0116) did not adjust the Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that it lacks jurisdiction over the revised NPRs and hereby dismisses the revised NPR appeals for the three Providers. Because jurisdiction over a provider is a requisite to granting a request for EJR, the Board hereby denies the Providers' request for EJR for the revised NPRs. Each of the Providers' have appeals of their original NPRs that will remain pending before the Board.

[38] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).

*B. Jurisdiction and EJR over the Remaining Providers*

The Board has determined that the remaining participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[39] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction over the above-captioned appeal and the underlying, remaining participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeal in this EJR request involves the cost reporting period 2012. Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[40] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[41] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request.

The Board finds that:

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

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

8/15/2019

X Clayton J. Nix

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

Enclosures: Schedule of Providers

cc: Bruce Snyder, Novitas (Electronic Mail w/Schedule of Providers)
Wilson Leong, FSS (Electronic Mail w/Schedule of Providers)

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

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**RE:** ***Jurisdictional Decision***
SRI 2010 SSI Realignment Optional Group
Provider No: Various
PRRB Case No. 16-0188G

Dear Mr. Putnam and Ms. Hartley,

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

**Background**

On November 2, 2015, the Group representative submitted a Model Form B ("Group Appeal Request") in order to establish a CIRP Group (PRRB Case No. 16-0188G). The Providers presented one issue—SSI Realignment. The appeal request contained the following summarized issue:

> The Provider challenges the sample period used to determine the hospital's SSI ratio. The current calculation is based on a sample period covering Federal Fiscal Year 2006 rather than a period covering the hospital's Fiscal Year.[1]

Additionally, the group requested that the sample period used to determine the hospital's ratio be revised to match the hospital's federal fiscal year.[2]

In its jurisdictional challenge, the Medicare Contractor asserted that the Providers' contentions are not an appealable issue because the decision to change the federal fiscal year end to a hospital's fiscal year end is a hospital election.[3] In order to make this election, a provider must send a written request to the Centers for Medicare and Medicaid Services, through its

[1] PRRB Case No. 16-0188G Group Appeal Request at Tab 2.
[2] *Id*.
[3] Medicare Administrative Contractor's Jurisdictional Challenge at 1.

intermediary.[4] Further, the Medicare Contractor argues that, "[t]hrough its request for realignment, the provider has chosen to pursue its available remedy, and(sic) therefore, it is not appropriate to include this issue in the PRRB appeal."[5]

**Board's Decision**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if: 1) it is dissatisfied with the final determination of the intermediary; 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 Board finds that it does not have jurisdiction over the SSI Realignment group issue because there is no final determination from which the Providers are appealing. Under 42 C.F.R. § 412.106(b)(3) a hospital may elect to use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period belongs solely to the hospital, which must submit a written request to the Medicare Contractor. Without these requests it is not possible for the Medicare Contractor to have issued a final determination from which any of the Providers could appeal. Furthermore, even if a Provider had requested a realignment from the federal fiscal year to its cost reporting year, 42 C.F.R. § 412.106(b)(3) makes clear that the Provider must use the data from its cost reporting year. There is no appeal right that stems from a realignment request.

**Conclusion**

The Board finds that it does not have jurisdiction over the group SSI Realignment issue, therefore PRRB Case No. 16-0188G is hereby closed and removed from the Board's docket.

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

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

[4] *Id*.
[5] *Id*. at 3.

FOR THE BOARD:

8/15/2019

X Gregory H. Ziegler

Gregory H. Ziegler, CPA, CPC-A
Board Member
Signed by: Gregory H. Ziegler -S

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

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**Electronic Delivery**

James Ravindran
Quality Reimbursement Services
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**RE:** ***EJR Determination***
QRS WVUHS 206 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
Case No. 17-2145GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 25, 2019 request for expedited judicial review ("EJR") for the appeal referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this appeal is:

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

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

[19] 69 Fed. Reg. at 49099.

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

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

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

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

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

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

**Provider's Request for EJR**

The Provider explains that "[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The '2004 Rule') The Board is bound by the 2004 rule."[29] Accordingly, the Providers contend that the Board should grant their request for EJR.

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

**Decision of the Board**

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

Jurisdiction

The participant that comprise the group appeal within this EJR request have filed an appeal involving fiscal year 2006.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[30] In that case, the Supreme Court concluded that a cost

[27] *Id.* at 943.
[28] *Id.* at 943-945.
[29] Providers' EJR Request at 1.
[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

report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[31]

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

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

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

The Board has determined that the participant involved with the instant EJR request are governed by Bethesda. Although case number 17-2145GC was established as a group appeal, it only has a

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Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

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

[32] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

[33] 201 F. Supp. 3d 131 (D.D.C. 2016).

[34] *Id*. at 142.

[35] See 42 C.F.R. § 405.1889(b)(1) (2008).

single participant and the Board is electing to treatment the case as an individual appeal. The appeal was timely filed and the $10,000 amount in controversy for an individual appeal has been met.[36] The Provider filed its appeal from a revised NPR which adjusted Part C Days as required by 42 C.F.R. § 405.1889 for Board jurisdiction. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying Provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

[36] 42 C.F.R. § 405.1835(a)(2).
[37] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[38] *See* 42 U.S.C. § 1395oo(f)(1).

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

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

Board Members Participating:

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

FOR THE BOARD:

8/15/2019

X Clayton J. Nix

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

Enclosures: Schedule of Providers

cc: Laurie Polson, Palmetto GBA c/o NGS (J-M)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
UH Regional Hospitals (36-0075)
FYE: 09/30/2014
PRRB Case No.: 14-2130

Dear Ms. Goron and Ms. Cummings,

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

**Pertinent Facts**

On January 29, 2014 the Provider submitted an Individual Appeal Request that presented one issue—Uncompensated Care Calculation.[1] The Provider filed its appeal request from a Federal Register Notice dated August 19, 2013.[2]

On January 23, 2015, the Medicare Contractor filed a jurisdictional challenge. In its challenge, the Medicare Contractor argued that the Board lacks subject matter jurisdiction.[3] The Medicare Contractor contends that the Provider's challenge to its uncompensated care calculation is ". . . procedurally invalid, arbitrary and capricious and outside the statutory authority of the Centers for Medicare and Medicaid Services."[4]

In its jurisdictional response, submitted May 8, 2015, the Provider argued that the Board does have jurisdiction over the issue because uninsured patient percentage is not barred by 42 U.S.C. § 1395ww(r)(3).[5] Further, the Provider argued that the provisions of 42 U.S.C. § 1395ww(r)(3) demonstrate Congress's intent to put administrative review on the same footing as judicial review.[6] The Provider concluded that the ban on judicial review does not apply in connection with mandamus type claims, challenges to regulations, and constitutional challenges.[7]

[1] Provider's Individual Appeal Request at Tab 3.
[2] 78 Fed. Reg. 50495, 50621 (Aug. 19, 2013).
[3] The Medicare Contractor's Jurisdictional Challenge at 2.
[4] *Id*. at 4.
[5] Provider's Jurisdictional Response at 5.
[6] *Id*.
[7] *Id*.

**Board's Decision**

The Board finds that it lacks jurisdiction over the DSH UCC payment in the instant appeal pursuant to 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review under 42 U.S.C. §§ 1395ff and 1395oo is precluded for:

(a) Any estimate of the Secretary for purposes of determining the factors described in paragraph( 2).[8]
(b) Any period selected by the Secretary for such purposes.

Additionally, in *Fla, Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health and Human Servs.*, 830 F.3d 515 (D.C. Cir. 2016) ("*Tampa General*"), the D.C. Circuit Court affirmed the D.C. District Court's decision[9] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013 (rather than data updated in April 2013) when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but instead the underlying data relied on by the Secretary. Therefore, judicial review was not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims. By challenging the use of the March 2013 update data, the hospital was seeking review of the "estimate" used by the secretary to determine the factors used to calculate the additional payments. The D.C. Circuit Court found that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[10] Further, the Court rejected Tampa General's assertion that it could challenge the underlying data, by determining that there cannot be judicial review of the underlying data as it is "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[11]

Moreover, the District Court addressed Tampa General's attempt to reframe the subject of the challenge as something other the Secretary's estimate. Specifically, it rejected the characterization that the challenge was one against "general rules leading to the estimate rather than as a challenge to the estimate itself[]" because it was an attempt to overturn a protected determination.[12] Finally, the Court addressed the contention that the estimate made by the Secretary was *ultra vires*, beyond the scope of statutory authority. It found that "the Secretary's choice of data is not obviously beyond the terms of the statute.[13]

[8] The UCC is comprised of three factors: 1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); 2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and 3) the hospital specific value that expresses the proportion of estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631and 50634.
[9] 89 F. Supp. 3d 121 (D.D.C. 2015).
[10] 830 F.3d at 517.
[11] *Id*. at 519.
[12] *Id*. at 521-22.
[13] *Id*. at 522.

The D.C. Circuit focused on the judicial and administrative bar reviewed in *DCH Regional Med. Ctr. V. Azar*, 925 F.3d 503 (D.C. Cir. 2019). In this case, the Provider claimed that it was challenging the methodology adopted and utilized by the Secretary to calculate Factor 3 of the DSH payment. It stated that the bar on review was only applicable to the estimates themselves, and excluded the methodology used to make the estimates. However, the Court rejected the argument, reasoning that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves", and that there is "no way to review the Secretary's method of estimation without reviewing the estimation itself." Further, the court noted that allowing the objection to the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Consequently, as the court previously held in *Tampa General* that that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates, it determined that the same connection existed in regard to the methodology used to generate the estimates.

**Conclusion**

The Board finds that it does not have jurisdiction over the uncompensated care calculation issue in the instant appeal because judicial and administrative review of the calculation is barred by statute and regulation. As in *Tampa General*, the Provider is challenging the payment for uncompensated care it is set to receive for fiscal year 2014. Therefore, the Provider is seeking review of the "estimate" used by the Secretary to determine the factors used in its final payment amounts, which is prohibited.

As the Uncompensated Care Calculation issue is the only issue in the appeal, PRRB case no. 14-2130 is hereby closed and removed from the Board's Docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

8/19/2019

X Charlotte F. Benson

Charlotte F. Benson
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**RE:** ***Jurisdictional Determination***

16-2363GC Essentia Health 2009 LIP Accuracy of CMS Developed SSI Ratio CIRP Group
16-2368GC Essentia Health 2009 LIP Inclusion of Medicare Part A Unpaid Days in SSI Ratio Issued 3/16/12 CIRP Group

Dear Mr. Chinea and Ms. Hartley:

This case involves the Providers' appeals of Medicare reimbursement for the fiscal years ending ("FYE") on June 30, 2009 and December 31, 2009. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Medicare Rehab Low Income Payment ("LIP")—Accuracy of CMS Developed SSI Ratio or Inclusion of Medicare Part A Days—issues and dismisses the instant appeals.

## Pertinent Facts

On September 6, 2016, the Board received the group representative's requests for hearing ("RFH") for fiscal year ends June 30, 2009 and December 31, 2009. The group issue in Case No. 16-2363GC concerns the Medicare Rehab Unit LIP—Accuracy of CMS Development SSI Ratio. The group issue in Case No. 16-2368GC concerns the Medicare Rehab LIP—Inclusion of Medicare Part A Days in the SSI Ratio.

## Board's Analysis and Decision

### Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider

has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

**Rehab Medicare LIP**

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[1]

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[2] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[3]

In the instant appeals, the Providers seek that the Board review the LIP SSI Ratio issue and the LIP Medicare Part A Days in the SSI Ratio issue.[4] As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Providers' appeal of the LIP adjustment and dismisses the issue in the instant appeal that challenges this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent because the Providers could bring suit in the D.C. Circuit.[5]

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[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).
[2] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).
[3] *Mercy*, 891 F.3d at 1068.
[4] Model Form B- Formation of Group Appeal Request Tab 2.
[5] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross*

PRRB Case Nos. 16-2363GC and 16-2368GC are hereby closed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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For the Board:

8/19/2019

X Charlotte F. Benson

Charlotte F. Benson
Board Member
Signed by: PIV

Cc: Wilson Leong, Federal Specialized Services

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Via Electronic Delivery**

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Universal Health Services, Inc.
Mary Hewlings
Program Manager
367 South Gulph Road
King of Prussia, PA 19406-0958

**RE:** ***Jurisdictional Determination***

17-1329GC UHS 2014 IRF LIP SSI Ratio CIRP Group
18-1755GC UHS 2015 IRF LIP Ratio CIRP Group

Dear Mr. Morgan, Ms. Hewlings, and Mr. Snyder:

This case involves the Providers' appeals of Medicare reimbursement for the fiscal years ending ("FYE") 2014 and 2015. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' LIP SSI ratio issues and dismisses the appeals.

## Pertinent Facts

On April 7, 2017, the group representative submitted a Request to Form Mandatory Group Appeal ("RFH") and attached the Model Form B (Group Appeal Group) in order to establish a CIRP group for 2014 (PRRB Case No. 17-1329GC). The Providers presented one issue—LIP SSI Ratio. The RFH included the following issue:

> UHS is appealing the Rehab LIP SSI ratios on the 2014 cost reports. We believe that CMS[‘] decision not to permit a hospital to elect to use its cost report year rather than the federal fiscal year for its Rehab LIP SSI ratio is incorrect. (42 CFR 412.624(e)(2)) and (42 CFR 412.106(b)(3)).[1]

[1] Model Form B Group-Formation of Group Request Tab 2.

On September 25, 2018, the group representative submitted a second RFH to establish a CIRP Group for 2015 (PRRB Case No. 18-1755GC). The RFH included the following issue:

> UHS is appealing the Rehab LIP SSI ratios on the 2015 cost reports. We believe that CMS[‘] decision not to permit a hospital to elect to use its cost report year rather than the federal fiscal year for its Rehab LIP SSI ratio is incorrect. (42 CFR 412.624(e)(2)) and (42 CFR 412.106(b)(3)).

## Board’s Analysis and Decision

### Applicable Regulatory Provisions and Board Rules

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

### Rehab Medicare LIP

The Board concludes that it does not have jurisdiction over the LIP SSI issues in these group appeals as the Providers are appealing FY 2014 and FY 2015 cost reporting periods, which is after the October 1, 2013 effective date of the regulatory revision to 42 C.F.R. § 412.630 that precludes Board review of the LIP adjustment.

In reviewing the LIP issues in this appeal, the Board first looked to the statutory provision prohibiting certain judicial and administrative review. 42 U.S.C. § 1395ww(j)(8) specifies:

> There shall be no administrative or judicial review . . . of the *establishment* of—
>
> (A) case mix groups, of the methodology for the classification of patients within such groups, and the appropriate weighting factors thereof under paragraph (2),
>
> (B) the prospective payment rates under paragraph (3),

> (C) outlier and special payments under paragraph (4), and
>
> (D) area wage adjustments under paragraph (6).[2]

The Secretary adopted a regulation limiting administrative and judicial review which mirrors the statutory limitations, specifically limiting review only to the "unadjusted" Federal payment rate. For the years prior to these appeals, 42 C.F.R. § 412.630 stated:

> Administrative or judicial review under 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factor, the *unadjusted* Federal per discharge payments rates, additional payments for outliers and special payments, and the area wage index.[3]

Significantly, the term "the unadjusted Federal rate" is defined in 42 C.F.R. § 412.624(c) and it does not include any of the adjustments discussed in § 412.624(e), including the LIP adjustment.

In the August 2013 Inpatient Rehabilitation Facility Prospective Payment System ("IRF PPS") Final Rule, the Secretary expanded the list of adjustments in § 412.630 to include the LIP adjustment. CMS stated in the Final Rule:

> Our intent was to honor the full breadth of the preclusion of administrative or judicial review provided by section 1886(j)(8) of the Act. However, the regulatory text reflecting the preclusion of review has been at times improperly interpreted to allow review of adjustments authorized under section 1886(j)(3)(v) of the Act. Because we interpret the preclusion of review at § 1886(j)(8) of the Act to apply to all payments authorized under section 1886(j)(3) of the Act, we do not believe that there should be administrative or judicial review of any part of the prospective rate. Accordingly, we are clarifying our regulation at § 412.630 by deleting the word "unadjusted" so that the regulation will clearly preclude review of the "Federal per discharge payment rates."[4]

During the periods at issue in these group appeals, the Board finds that the revised regulation precluded review of the LIP adjustment. As such, the Board concludes that it does not have jurisdiction over the LIP issues in the group appeals.

PRRB Case Nos. 17-1329GC and 18-1755GC are hereby closed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

---

[2] (Emphasis added).
[3] (Emphasis added).
[4] 78 Fed. Reg. at 47900.

Board Members Participating:

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

For the Board:

8/19/2019

X Charlotte F. Benson

Charlotte F. Benson
Board Member
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**RE:** ***Jurisdictional Determination***

| | |
|---|---|
| 18-0463GC | Providence St. Joseph Health 2015 LIP Accuracy of CMS Developed SSI Ratio CIRP Group |
| 18-0464GC | Providence St. Joseph Health 2015 LIP Exclusion of Dual Eligible Part A Unpaid Days—Medicaid Ratio CIRP Group |
| 18-0465GC | Providence St. Joseph Health 2015 LIP Exclusion of Dual Eligible Part C Days from the Medicaid Ratio CIRP Group |
| 18-0466GC | Providence St. Joseph Health 2015 LIP Inclusion of Medicare Part A Unpaid Days in the SSI Ratio CIRP Group |
| 18-0467GC | Providence St. Joseph Health 2015 LIP Inclusion of Medicare Part C Days in the SSI Ratio CIRP Group |

Dear Mr. Chinea and Ms. Frewert:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") on June 30, 2015. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Medicare Rehab Unit Low Income Payment ("LIP") adjustment issues and dismisses the instant appeals.

## Pertinent Facts

On January 10, 2018, the Board received the group representative's requests for hearing ("RFH") for fiscal year end 06/30/2015. The following groups were created for the corresponding issues:

1. Case No. 18-0463GC—LIP Accuracy of CMS Developed SSI Ratio
2. Case No. 18-0463GC—LIP Exclusion of Dual Eligible Part A Unpaid Days from the Medicaid Ratio
3. Case No. 18-0465GC—LIP Exclusion of Dual Eligible Part C Days from the Medicaid Ratio
4. Case No. 18-0466GC—LIP Inclusion of Medicare Part A Unpaid Days in the SSI Ratio
5. Case No. 18-0467GC—LIP Inclusion of Medicare Part C Days in the SSI Ratio

## Board's Analysis and Decision

### Applicable Regulatory Provisions and Board Rules

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

### Rehab Medicare LIP

The Board concludes that it does not have jurisdiction over the LIP issues in these group appeals as the Providers are appealing FY 2015 cost reporting periods, which is after the October 1, 2013 effective date of the regulatory revision to 42 C.F.R. § 412.630 that precludes Board review of the LIP adjustment.

In reviewing the LIP issues in this appeal, the Board first looked to the statutory provision prohibiting certain judicial and administrative review. 42 U.S.C. § 1395ww(j)(8) specifies:

> There shall be no administrative or judicial review . . . of the *establishment* of—
>
> (A) case mix groups, of the methodology for the classification of patients within such groups, and the appropriate weighting factors thereof under paragraph (2),
>
> (B) the prospective payment rates under paragraph (3),
>
> (C) outlier and special payments under paragraph (4), and
>
> (D) area wage adjustments under paragraph (6).[1]

The Secretary adopted a regulation limiting administrative and judicial review which mirrors the statutory limitations, specifically limiting review only to the "unadjusted" Federal payment rate. For the years prior to these appeals, 42 C.F.R. § 412.630 stated:

[1] (Emphasis added).

> Administrative or judicial review under 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factor, the *unadjusted* Federal per discharge payments rates, additional payments for outliers and special payments, and the area wage index.[2]

Significantly, the term "the unadjusted Federal rate" is defined in 42 C.F.R. § 412.624(c) and it does not include any of the adjustments discussed in § 412.624(e), including the LIP adjustment.

The Board finds that in the August 2013 Inpatient Rehabilitation Facility Prospective Payment System ("IRF PPS") Final Rule, the Secretary expanded the list of adjustments in § 412.630 to include the LIP adjustment. CMS stated in the Final Rule:

> Our intent was to honor the full breadth of the preclusion of administrative or judicial review provided by section 1886(j)(8) of the Act. However, the regulatory text reflecting the preclusion of review has been at times improperly interpreted to allow review of adjustments authorized under section 1886(j)(3)(v) of the Act. Because we interpret the preclusion of review at § 1886(j)(8) of the Act to apply to all payments authorized under section 1886(j)(3) of the Act, we do not believe that there should be administrative or judicial review of any part of the prospective rate. Accordingly, we are clarifying our regulation at § 412.630 by deleting the word "unadjusted" so that the regulation will clearly preclude review of the "Federal per discharge payment rates."[3]

During the period at issue in these group appeals, the Board finds that the revised regulation precluded review of the LIP adjustment. As such, the Board concludes that it does not have jurisdiction over the LIP issues in the group appeals.

PRRB Case Nos. 18-0463GC, 18-0464GC, 18-0465GC, 18-0466GC, 18-0467GC are hereby closed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

[2] (Emphasis added).
[3] 78 Fed. Reg. at 47900.

For the Board:

8/19/2019

X Charlotte F. Benson

Charlotte F. Benson
Board Member
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

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RE: ***Jurisdictional Determination***
Parkview Medical Center (Provider No. 06-0020)
FYE 06/30/2015
PRRB Case No. 19-0395

Dear Ms. Gunn and Mr. Lattimore,

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

**Background**

Parkview Medical Center is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in an Original notice of Program Reimbursement ("NPR") dated May 31, 2018 for fiscal year end ("FYE") June 30, 2015. The Provider timely filed an appeal from the NPR on November 26, 2018. The Model Form A-Individual Appeal Request presented three issues:

1. DSH/SSI (Provider Specific)
2. Outlier Fixed Loss Threshold
3. 2 Midnight Census IPPS Payment Reduction

On January 30, 2019, the Provider transferred the Two Midnight Rule issue to PRRB Case No. 19-0863GC (QRS CY 2015 Two Midnight Census IPPS Payment Reduction Group). On July 10, 2019, the Provider withdrew the Outlier Fixed Loss Threshold issue, leaving only the SSI Provider Specific issue remaining in the appeal.

**Board's Decision**

As set forth below, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue.

The Provider's individual appeal is based on the contention that the SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients entitled to SSI benefits in the Provider's DSH calculation. This issue is duplicative of the SSI Systemic Errors

issue that the Provider directly added to Case No. 18-1409GC on November 26, 2018. The Providers in that CIRP Group challenge their SSI percentages because of disagreement over how the SSI percentage is calculated and contend that CMS has not properly computed the SSI percentage because it failed to include all patients entitled to SSI benefits in the calculation. Pursuant to Board Rule 4.6.1, "A provider may not appeal an issue from a single determination in more than one appeal." Therefore, the Board finds that the SSI Provider specific issue is duplicative of the issue the Provider is appealing in the group appeal and hereby dismisses this aspect of the SSI Provider specific issue.

In its SSI Provider Specific issue statement, the Provider also asserts that it "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period." Under 42 C.F.R. § 412.106(b)(3), "if a hospital prefers that CMS use its cost reporting data instead of the Federal Fiscal Year, it must furnish to CMS, through its intermediary, a written request…" Without a written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for purposes of appeal. Additionally, even if the Provider has requested (and received) a realignment of its SSI percentage, that is not a final determination from which the Provider can appeal, or with which the Provider can be dissatisfied, as required by 42 C.F.R. § 405.1835(a). Therefore, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's SSI Provider Specific issue.

**Conclusion**

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the issue being pursued in a group appeal and there is no final determination with respect to the realignment portion of the issue statement.

As no issues remain pending in the appeal, PRRB Case No. 19-0395 is hereby closed and removed from the Board's docket.

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

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

FOR THE BOARD:

8/19/2019

X Gregory H. Ziegler

Gregory H. Ziegler, CPA, CPC-A
Board Member
Signed by: Gregory H. Ziegler -S

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Delivery**

Corinna Goron
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RE: **EJR Determination**
14-1278GC HRS LSU 2009 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-3003GC HRS THR 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 25, 2019 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

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

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

> calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20]

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

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

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

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[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] 72 Fed. Reg. at 47411.
[23] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the

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

**Providers' Request for EJR**

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

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

**Decision of the Board**

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

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Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.
[29] No. 17-1484, 2019 WL 2331304 (June 3, 2019).

*Jurisdiction*

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

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

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

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

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

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

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

*A. Appeal of a Revised Notice of Program Reimbursement (NPR)*

In Case No. 14-1278GC, Participant # 1, University Health Shreveport (Provider No. 19-0098, FYE 6/30/2009), appealed a revised NPR that did not adjust the Part C issue as required for Board jurisdiction. The regulation, 42 C.F.R. § 405.1889 (2012), states the following regarding appeal rights from revised determinations (including revised NPRs):

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of . . . § 405.1835 . . . of this subpart are applicable.
>
> (b)(1) Only those matters that are *specifically* revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (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 adjustment referenced revised Medicaid eligible days. The documentation did not support that Part C days were "specifically" adjusted in the revised NPR. Since the revised NPR for Participant # 1, University Health Shreveport, did not "specifically" adjust the Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that it lacks jurisdiction over the revised NPR and hereby dismisses Participant #1's appeal of that revised NPR from Case No. 14-1278GC. Because jurisdiction over a provider is a requisite to granting a request for EJR, the Board hereby denies the Provider's request for EJR in Case No. 14-1278GC as it relates to that revised NPR.[36]

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[35] See 42 C.F.R. § 405.1889(b)(1) (2008).
[36] *See* 42 C.F.R. § 405.1842(a).

*B. Jurisdiction and EJR for the Remaining Providers*

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

*Board's Analysis Regarding the Appealed Issue*

The appeals in this EJR request involve the 2009 and 2011 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[38] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[39] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

*Board's Decision Regarding the EJR Request*

The Board finds that:

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

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

8/21/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Justin Lattimore, Novitas Solutions
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Mark Polston
King & Spalding, LLP
1700 Pennsylvania Avenue, Suite 200
Washington, DC 20006-2706

RE: King & Spalding FFY 2014 NPR 0.2 Percent IPPS Rate Reduction Group
Case No. 17-1831G

Dear Mr. Polston,

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeal and, on February 6, 2019, as required by 42 C.F.R. § 405.1842(c), notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above referenced group case. The Providers and the Medicare Contractor have submitted comments as to whether the Board is without the authority to decide the following legal question:

> Whether the Secretary's 0.2 percent adjustment to the Medicare hospital inpatient prospective system ("IPPS") standardized amount in FFY 2014 to account for the adoption of the "Two-Midnight" rule was lawful; and if lawful, whether the adjustment (-0.2 percent) was in the correct amount.[1]

With regard to the proposed EJR, the Providers simply state that the Board has granted EJR with respect to this issue in the past and that they have no objection to the Board doing so here.[2] In their comments, the Medicare Contractor points out that this group of providers did not challenge the 2-Midnight Rule by appealing the annual IPPS rule published in the Federal Register.[3] The Medicare Contractor suggests that the Providers are challenging the rule through the appeal of their NPRs, which were issued after the remedial 0.6 percent positive adjustment to the IPPS rates in 2017. As a result, the Medicare Contractor maintains that the Providers should be able to more accurately determine what (if any) the true amount in controversy is based on the cumulative impact of the 2-Midnight Rule. Finally, the Medicare Contractor notes that certain "ongoing" *Shands* litigation was just disposed of via summary judgment in favor of the Secretary's handling of the 2-Midnight Rule in the District Court for the District of Columbia ("D.C.").[4]

The relevant statutory provisions and regulations for this issue are set forth below.

[1] Provider's Group Appeal Request, Tab 2 at 1.
[2] Provider's Comments on Board's Proposed EJR (Apr. 8, 2019).
[3] MAC's Comments on Board's Proposed EJR, 1 (Mar. 8, 2019).
[4] *Id.* at 2-3 (citing to *Shands Jacksonville Med. Ctr., Inc. v. Azar*, 366 F. Supp. 3d 32 (D.D.C. 2018).

**Statutory and Regulatory Background**

In the final IPPS rule for FFY 2014,[5] the Secretary of Health and Human Services ("Secretary") indicated that she had expressed concern in the proposed calendar year Outpatient PPS ("OPPS") rule[6] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services.[7] It was observed that the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours had risen from approximately 3 percent in 2006 to 8 percent in 2011.[8] This raised a concern about the financial impact on Medicare beneficiaries who may pay more for the same services as outpatients than they would if they were admitted to the hospital as inpatients.[9]

The Secretary noted that the trend toward outpatient status with extended observation services may have been attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied by the Medicare review contractor. Such claims were denied when the contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS had been advised by stakeholders that the hospitals appeared to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review. They were doing this by treating beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. [10]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary.[11]

The Secretary also reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. At the time, the Medicare Benefit Policy Manual stated that, once the reason for the observation care is resolved, the typical decision to admit a beneficiary as an inpatient can usually be made within 24 hours, and most within 48 hours. It also stated that an overnight stay may be a factor in the admission decision. Physicians were to use the 24-hour or overnight period as a benchmark, that is, patients who were expected to need care for 24 hours or overnight should have been admitted as inpatients. Generally, a beneficiary was considered

[5] 78 Fed. Reg. 50495 (Aug. 19, 2013).
[6] 77 Fed. Reg. 45061, 45155-57 (July 30, 2012). *See also* 77 Fed. Reg. 68210, 68426-33 (Nov. 15, 2012) (the final rule with comment period).
[7] 78 Fed. Reg. at 50906.
[8] *Id.* at 50907.
[9] *Id.*
[10] *Id.*
[11] *Id.*

an inpatient if formally admitted with the expectation that he or she would remain in the hospital overnight, regardless of whether there was a later transfer or discharge resulting in no overnight patient stay. It explained that only rare and exceptional cases require reasonable and necessary observation services which span more than 48 hours. Length of stay, however, is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[12]

In the FFY 2014 IPPS proposed rule,[13] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment. This became known as the "2-Midnight Rule." Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[14]

The 2-Midnight Rule

In the final 2014 IPPS rule, the Secretary pointed out that CMS had established policy that recognized there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule adopted the 2-Midnight Rule, providing instructions that gave a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designated services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided.[16]

The Secretary's actuaries estimated that the 2-Midnight Rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving

[12] *See* 78 Fed. Reg. at 50907-08 (*citing* Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 6, § 20.6 & Ch. 1, § 10).
[13] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).
[14] 78 Fed. Reg. at 50908.
[15] 78 Fed. Reg. at 50944.
[16] *Id.*

from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, causing a net shift of 40,000 encounters to inpatient.[17] This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay inpatient encounters to outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters.[18]

In light of the impact of the 2-Midnight Rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-Midnight Rule. Consequently, the standardized amount was reduced by 0.2 percent.[19] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[20]

In the proposed 2016 OPPS rule, the Secretary noted that the data was, at that point, consistent with the assumptions used to develop the 0.2 percent adjustment estimate. Long outpatient stays and very short inpatient stays were declining, while 2-4 day inpatient stays increased.[21] As time went on, however, the impact of the shift between inpatient and outpatient encounters proved to be more complex than anticipated, and in the proposed 2017 IPPS rule, the Secretary proposed removing the reduction beginning in FY 2017.[22] The Secretary also proposed a one-time prospective increase of 0.6 percent in FY 2017 to address the effect of the 0.2 percent reductions in FYs 2014, 2015, and 2016.[23] The 0.2 percent reduction was removed indefinitely, and the one-time increase of 0.6 percent was adopted for FY 2017 in the final IPPS rule for 2017.[24] In the final IPPS rule for 2018, the one-time 0.6 percent increase was removed for FY 2018.[25]

## Decision of the Board

The Board has reviewed the Providers' Group Appeal Request and the parties' comments regarding the proposed own motion EJR determination. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a). With respect

[17] *Id.* at 50952.
[18] *Id.* at 50952-53.
[19] *Id.*
[20] *Id.* at 50990.
[21] 80 Fed. Reg. 39199, 39370 (July 8, 2015).
[22] 81 Fed. Reg. 24945, 25140 (Apr. 27, 2016).
[23] *Id.*
[24] 81 Fed Reg. 56761, 57059 (Aug. 22, 2016).
[25] 82 Fed. Reg. 37990, 38287-88 (Aug. 14, 2017).

to jurisdiction, the Board concludes that the Providers timely appealed from their NPRs and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[26]

The Medicare Contractor suggests that the Board should require the Providers to more accurately determine what (if any) the true amount in controversy is based on the cumulative impact of the 2-Midnight Rule and the remedial 0.6 percent positive adjustment to the IPPS rates in 2017. However, the amount in controversy requirement set forth in 42 U.S.C. § 1395oo(a)(2) is nothing more than a jurisdictional provision, and no extensive fact-finding is necessary to determine that it exceeds the jurisdictional threshold.[27] Indeed, the amount in controversy is normally determined from the face of the pleadings.[28] Federal courts have found the amount in controversy requirement set forth in 42 U.S.C. § 1395oo(a)(2) to be comparable to the amount in controversy provision for diversity cases under 28 U.S.C. § 1332, for which the Supreme Court has held that the sum claimed by the plaintiff controls if the claim is apparently made in good faith.[29] The Board finds that the amounts claimed by the Providers were made in good faith.

Consequently, the Board has determined that it has jurisdiction over the appeal. This issue involves a challenge to the validity of a provision found in the proposed and final rules for FFY 2014 that the Secretary published in the Federal Register pursuant to her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i). Significantly, § 1395ww(d)(5)(I)(i) specifies that the Secretary's *must* exercise her "exceptions and adjustments" authority "by regulation." Accordingly, the Board finds that the provision at issue that was published pursuant to § 1395ww(d)(5)(I)(i) are regulations and that, in this regard, it lacks the authority to decide the legal question of whether the Secretary's 0.2 percent adjustment to the Medicare hospital IPPS standardized amount in final rule for FFY 2014 to account for the adoption of the "Two-Midnight" rule was lawful; and if lawful, whether the adjustment (-0.2 percent) was in the correct amount.

The Board finds that:

1) It has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding the decrease in IPPS payments due to the 2-Midnight Rule, there are no findings of fact for resolution by the Board;

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[26] *See* 42 C.F.R. § 405.1837(a).
[27] *See Russell-Murray Hospice, Inc. v. Sebelius*, 724 F. Supp. 2d 43, 56 (D.D.C. 2010).
[28] *See Beacon Healthcare Servs., Inc. v. Leavitt*, 629 F.3d 981, 984 (9th Cir. 2010).
[29] *See Infinity Care of Tulsa v. Sebelius*, 2011 WL 778111, 3 (N.D. Okla. 2010). *See also Russell-Murray Hospice, Inc.*, 724 F. Supp. 2d at 56 ("To require the PRRB to gather data and perform a detailed calculation of the specific amount in controversy simply to establish its jurisdiction to hear an appeal would represent a significant departure from the established scope of jurisdictional fact-finding . . ."); *IHG Healthcare v. Sebelius*, 717 F. Supp. 2d 696, 706 (S.D. Tex. 2010) ("When the amount in controversy is put in issue, a federal court generally asks whether it is facially apparent from the complaint that the plaintiff seeks recovery in an amount greater than the jurisdictional minimum. . . . But the court can find no reason, or authority, for requiring the PPRB to undertake more arduous fact-finding in evaluating its jurisdiction[.]" (citations omitted)).

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 whether the Secretary's 0.2 percent adjustment to the Medicare hospital IPPS standardized amount in the final rule for FFY 2014 to account for the adoption of the "Two-Midnight" rule was lawful; and if lawful, whether the adjustment (-0.2 percent) was in the correct amount.

Accordingly, the Board finds that the 2-Midnight Rule issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject year.

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

Board Members Participating:

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

For the Board:

8/21/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Electronic Delivery**

Russell Kramer
Quality Reimbursement Services
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Arcadia, CA 91006

RE: **Request to Reconsider and Request for Expedited Judicial Review**

13-3126GC QRS WFHC 2008 DSH Medicare Managed Care Part C Days CIRP Group

Dear Mr. Kramer:

The Provider Reimbursement Review Board ("Board") issued a decision on June 27, 2019, in response to the Providers' June 4, 2019 Request to Reconsider (received June 5, 2019) and the subsequent request for expedited judicial review ("EJR") submitted June 10, 2019 for the appeal referenced above. The Board's June 27, 2019 decision incorrectly referenced a different group appeal and the letter contained additional errors; the Board has updated its decision and is now reissuing it.

The Board's determination regarding reconsideration and EJR is set forth below.

**Pertinent Facts**:

The QRS WFHC 2008 DSH Medicare Managed Care Part C Days CIRP Group was filed on August 24, 2013. Three participants formed the group (St. Francis Hospital (52-0078), All Saints Medical Center (52-0096), and St. Joseph's Regional Medical Center (52-0136). The Board acknowledged the case via email on August 30, 2013 and assigned it case no. 13-3126GC. An additional participant, Covenant Medical Center (16-0067), was transferred to the group on August 28, 2013.

As there had been no additional Direct Adds or Transfers to the group in more than 3 years, the Board issued a Status Request on February 13, 2017, requiring the Representative to advise the Board whether the group was fully formed or identify the Providers that had not yet received final determinations. The response was due in 30 days (March 5, 2017) or the appeal would be dismissed. When there was no response to the Board's status letter, a dismissal was issued by certified mail on May 10, 2017.

Two years later, on June 5, 2019, the Representative filed a reconsideration request. The Representative argues that the Board's closure does not constitute a final decision that would be appealable under 42 CRR 405.1877(a)(3)(i) because the Board Rules ". . . specifically treat a closure determination as separate and distinct from a dismissal. . . . Only a dismissal is a final decision appealable under § 405.1877(a)(3)(i)."[1] The Representative is requesting that the Board place the group appeal back on the docket or issue a final decision so that the Provider may seek judicial review of the Board's action. On June 10, 2019, the Representative requested expedited judicial review of the group appeal.

**Decision of the Board**

The Board hereby denies the Provider's request for reconsideration. Pursuant to 42 C.F.R. § 405.1868, the Provider Reimbursement Review Board ("Board") has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provision of section 1878 of the Act and of the regulations. The Board's powers include the authority to take appropriate actions in response to the failure of a party to comply with Board rules and orders. The Provider representative was notified in the Board's February 13, 2017 notice that "if you do no respond within the 30 days, it will be presumed that you are no longer pursuing the appeal and the case will be dismissed. The Board then dismissed the appeal on May 10, 2017, and included in the dismissal letter the appropriate appeal rights.

In *UHI v. Thompson (UHI)*, the Courts considered a similar matter, in determining whether a procedural dismissal constituted a final decision as set forth in the Medicare Act that was subject to review by the Federal Courts.[2] The decision rendered in that case explained that "The Medicare Act does not specifically limit final decisions to those involving a hearing . . . [*UHI*] involves a decision ending the plaintiff's appeal in a case that was dismissed following its journey through the administrative review process."[3] Further, the Court explained that ". . . a finding that we lack jurisdiction to review [*UHI*] would mean that administrative agencies could completely insulate themselves from judicial review simply by dismissing cases on procedural grounds prior to a hearing."[4]

As the final dismissal was issued on May 10, 2017, with appropriate appeal rights, no additional dismissal is warranted at this time. In addition, as the case remains in closed status, the request for EJR is hereby denied.

[1] Representative's June 5, 2019 Reconsideration Request at 1.
[2] *UHI v. Thompson*, 250 F. 3d. 993, 996 (6th Cir. 2001).
[3] *Id*.
[4] *Id*.

Board Members Participating:

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FOR THE BOARD:

8/22/2019

X Charlotte F. Benson

Charlotte F. Benson, CPA
Board Member
Signed by: PIV

cc: Danene Hartley, National Government Services, Inc.
Wilson Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

Quality Reimbursement Services
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Palmetto GBA c/o National Government Services
Laurie Polson, Appeals Lead
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P.O. Box 6474
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RE: AnMed Health d/b/a Anderson Area Medical Center (Provider No. 42-0027)
FYE September 30, 2006
Case No. 10-0832

Dear Mr. Ravindran and Ms. Polson,

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction in the above-referenced appeal involving the Provider's fiscal year ("FY") 2006. The Board's jurisdictional decision is set forth below.

## Background

The Provider submitted a request for hearing on March 19, 2010, based on a Notice of Program Reimbursement ("NPR") for FY 2006 dated September 24, 2009. The hearing request included two issues as follows:

> Issue 1 – The Intermediary failed to properly calculate the Medicare Proxy of the disproportionate share hospital (DSH) adjustment including use of an incorrect Supplemental Security Income (SSI) Percentage.
>
> Issue 2 – Revisions to the Provider's full-time equivalent (FTE) resident counts used to calculate the Provider's allowable graduate medical education (GME) and indirect medical education (IME) reimbursement[1]

The Provider added one issue via a letter dated May 20, 2010 as follows:

[1] This issue encompasses the prior and penultimate years' FTE counts and prior year intern to resident bed (IRB) ratio.

> Issue 3 – For purposes of calculating the graduate medical education (GME) and indirect medical education (IME) payments, the Intermediary failed to include all appropriate resident time in the full-time equivalent (FTE) count.[2]

In the hearing request, the Provider further elaborated on Issue 1 by stating the following:

> The Intermediary applied the SSI Percentage reported on Worksheet E, Part A, to agree to the rate published annually in the Federal Register. The Intermediary's calculation excluded Medicare days attributable to patients who were entitled to Medicare Part A and SSI, but not ***included*** in the Medicare proxy, and otherwise used improper data and flawed methodology to calculate the Medicare Proxy. Therefore, the Provider contends that the resulting DSH amount calculated by the Intermediary is understated.[3]

The parties submitted a partial administrative resolution on March 25, 2019 that resolved Issues 2 and 3. The Medicare Contractor submitted a jurisdictional challenge on Issue 1 on June 28, 2019. The Provider did not submit a responsive brief.

**Additional Facts:**

On April 22, 2011, the Medicare Contractor issued a Notice of Intent to Reopen the Provider's cost report FY 2006 indicating that it would reopen, "To revise the Medicare SSI fraction in the DSH calculation to ensure the accurate inclusion of Medicare Advantage data submitted by providers, which will be included in revised SSI ratios to be published by CMS."

On March 6, 2013, (after CMS published revised SSI ratios in March 2012), the Medicare Contractor issued a revised NPR for FY 2006 to incorporate the revised SSI percentage.

**Medicare Contractor's Position**

The Medicare Contractor contends that the Board does not have jurisdiction over Issue 1 because CMS Ruling 1498-R eliminated any actual case or controversy regarding a hospital's *previously calculated* SSI percentage and associated DSH payment and, thereby, rendered moot any appeal of the SSI percentage issued *prior to* the Ruling and stripped the Board of jurisdiction over it. Additionally, the Medicare Contractor contends that the Provider has improperly expanded the SSI percentage issue for FY 2006 to include Medicare Advantage ("Part C") and Dual Eligible ("DE") Exhausted and Medicare Secondary Payor ("MSP") days.[4]

The Medicare Contractor explains that it issued a Notice of Intent to Reopen the Provider's cost report for FY 2006 on April 22, 2011 indicating that it would reopen the FY 2006 cost report (as necessary), "To revise the Medicare SSI fraction in the DSH calculation to ensure the accurate

[2] This issue encompasses resident FTE counts in the rural track residency program.
[3] Provider's Appeal Request at Tab 3 (emphasis added).
[4] Medicare Contractor's jurisdictional challenge at 3.

inclusion of Medicare Advantage data submitted by providers, which will be included in revised SSI ratios to be published by CMS." CMS published revised SSI ratios in March 2012 in accordance with CMS Ruling 1498-R. The published revised SSI ratio for AnMed was 6.78 percent. The Medicare Contractor issued a revised NPR for FY 2006 on March 6, 2013 to incorporate the revised SSI percentage. Therefore, the Medicare Contractor has resolved the issue in dispute via the revised NPR. The Provider did ***not*** subsequently appeal the revised NPR.[5]

The Medicare Contractor goes on to argue that the Provider also has improperly expanded the issue under appeal. The Medicare Contractor explains that, in accordance with the Board Rules dated July 1, 2009 (which were the rules in effect at the time of this appeal filing), Board Rule 7.1(A) requires the Provider to give a concise issue statement describing the adjustment, including the adjustment number, why the adjustment is incorrect, and how the payment should be determined differently. In this appeal, the Provider specifically appealed the adjustments to the SSI percentage and stated: "The Intermediary's calculation excluded Medicare days attributable to patients who were entitled to Medicare Part A and SSI, but not *included* in the Medicare proxy, and otherwise used improper data and flawed methodology to calculate the Medicare Proxy."[6]

The Medicare Contractor states that in the Provider's Final Position Paper dated May 29, 2019, the Provider briefed DE Exhausted Benefit days, MSP days and Part C days. The Provider argues that these days should be *excluded* from the SSI percentage and included in its Medicaid fraction. The Medicare Contractor contends that the Board views these days as separate and distinct issues that must be separately appealed. Board Rule 8.2 gives specific examples of DSH sub-issues, including dual eligible days, general assistance days, charity care days, HMO days, etc. In this appeal, the Provider's issue statement only covers "the use of an incorrect SSI percentage" to include "improper data and [a] flawed methodology." The Provider did not specifically appeal DE Exhausted Benefit or Part C days. Therefore, the Provider has not complied with the regulations for filing a jurisdictionally valid appeal of these issues and these sub-arguments cannot be briefed in the appeal of the SSI percentage matching issue.[7]

## Board's Decision

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

The Board finds that Issue 1 in the appeal is subject to CMS Ruling 1498-R because Issue 1 was part of an appeal pending when CMS Ruling 1498-R was issued. In particular, CMS Ruling 1498-R rendered moot any appeal of the SSI percentage data matching issue prior to the Ruling. As a result, the Board does not have jurisdiction over the issue. The Board's only recourse would be to remand the issue to the Medicare Contractor pursuant to the Ruling. However, the Provider

[5] Medicare Contractor's jurisdictional challenge at 4.
[6] Medicare Contractor's jurisdictional challenge at 4 (emphasis added).
[7] Medicare Contractor's jurisdictional challenge at 7.

has already received the remand relief, which was the revised NPR with the newly calculated SSI percentage (*i.e.*, the March 6, 2013 revised NPR) and the Provider failed to subsequently appeal that revised NPR.

Further, the Board finds that it does not have jurisdiction over the Part C, DE Exhausted Benefit and MSP Days issues because the Provider did not properly appeal these issues. The appeal request which was filed with the Board in March 2010 was subject to the follow requirements under 405.1835(b):

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) An explanation…of the provider's dissatisfaction with the contractor's or Secretary's determination, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[8]

Board Rules elaborate on this regulatory requirement as follows:

> Your hearing request must contain an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending that the findings and conclusions are incorrect. . . . You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not define the issue as "DSH." You must precisely identify the component of the DSH issue that is in dispute.[9]

The Board finds that Issue 1 as stated in the original appeal request cannot be construed to include Part C, DE Exhausted Benefit and MSP Days issues. In this regard, the Board notes that Issue 1 as stated in the appeal request revolved around "including" days in the SSI percentage while the Part C, DE Exhausted Benefit and MSP Days issue revolve around *excluding* days from the SSI percentage so they can be included in the Medicaid fraction. Similarly, the Board notes that the appeal request's description of Issue 1 does not mention or discuss the Medicaid fraction. Because the Provider did not raise these issues in its initial appeal request (or timely

[8] 42 C.F.R. § 405.1835(b) (2008).
[9] Provider Reimbursement Review Board Instructions, Part I § B.II.a (2008), *available at* http://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html (last visited December 6, 2013).

and properly add them to the appeal), the Board concludes that it lacks jurisdiction over these issues and dismisses them from the appeal.

As no issues remain in the appeal, the Board hereby closes the case 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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For the Board:

8/22/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Mail**

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**RE:** ***Expedited Judicial Review Determination***
14-0348GC SWC SEH 2008-2010 DSH SSI Fraction Part C Days
14-0356GC SWC SEH 2008-2010 DSH Medicaid Fraction Part C Days

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' July 26, 2019 request for expedited judicial review (EJR) (received July 29, 2019) for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

> Whether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI[1] fraction and excluded from the Medicaid fraction numerator or vise-versa.[2]

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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

[1] "SSI" is the acronym for "Supplemental Security Income."
[2] Providers' EJR Request at 3.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[20] 69 Fed. Reg. at 49099.

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

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

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

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

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

**Providers' Request for EJR**

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[30]

In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[31] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

**Decision of the Board**

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

Jurisdiction

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

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

[30] 69 Fed. Reg. at 49,099.
[31] *Allina* at 1109.

*Bowen* ("*Bethesda*").[32] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[33]

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

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[37] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

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[32] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[33] *Bethesda at 1258-59.*
[34] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[35] 201 F. Supp. 3d 131 (D.D.C. 2016)
[36] *Banner* at 142.
[37] See 42 C.F.R. § 405.1889(b)(1) (2008).

*A. Jurisdictional Determination: Appeals of Revised NPRs and the SSI Realignment*

In both Case Nos. 14-0348GC and 14-0356GC, Provider ## 1 and 2 involve the same provider, St. Elizabeth Medical Center (Provider No. 18-0001), and its appeal of the revised NPRs for its FYEs 10/27/2008 and 12/31/2008, respectively. Neither of these revised NPRs adjusted the Part C issue as required for Board jurisdiction. Rather, the appeals are based on adjustments made as the result of SSI realignments. For both FYEs, the Provider requested "a recalculation of the Medicare SSI ratio. . . . based on the its own fiscal year" in accordance with the regulation 42 C.F.R. § 405.106(b)(3).[38] The SSI adjustments identified as the subject of the disputes in these cases reflect implementation of the SSI ratio realignment completed by the Medicare Contractor.

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

St. Elizabeth Medical Center (Provider No. 18-0001) requested that its SSI percentages be recalculated from the federal fiscal year to its respective cost reporting years for its FYEs 10/27/2008 and 12/31/2008. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used.[39] The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the September 30 FFY.[40]

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

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

[38] *See* the July 29, 2019 Jurisdictional Documents, 1.D and 2.D.
[39] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). Similarly, CMS' policy on Part C days was set in the FFY 2005 Final Rule and is incorporated into and reflected in this data matching process. *See* 75 Fed. Reg. at 50276, 50285-6.
[40] As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis.

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

Since the revised NPRs for #1 and #2 St. Elizabeth Medical Center (Provider No. 18-0001, FYEs 10/27/2008 and 12/31/2008) did not "specifically" adjust the Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that it lacks jurisdiction over these revised NPRs and hereby dismisses both appeals for St. Elizabeth's Hospital from Case Nos. 14-0348GC and 14-0356GC. Because jurisdiction over a provider is a requisite to granting a request for EJR, the Board hereby denies the Provider's request for EJR for the revised NPRs in both cases.

*B. Jurisdiction and EJR for the Remaining Providers*

The Board has determined that the remaining participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[41] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction over the above-captioned appeals and the underlying, remaining participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the cost reporting periods 2008-2010. Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[42] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[43] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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

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 group appeals are entitled to a hearing before the Board;

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

8/23/2019

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Judith Cummings, CGS Administrators (Electronic Mail w/Schedules of Providers)
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Delivery**

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**RE:** ***Jurisdictional Decision***
Dublin Methodist Hospital (Provider No. 36-0348)
FYE 06/30/2012
PRRB Case No. 14-3269

Dear Mr. Flynn and Ms. Cummings,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed Case No. 14-3269 in response to a jurisdictional challenge filed by the Medicare Contractor. The Board's findings and jurisdictional decision are explained below.

## Background:

Dublin Methodist Hospital (the "Provider") appealed an original Notice of Program Reimbursement ("NPR") dated December 4, 2013 for its fiscal year end ("FYE") June 30, 2012 cost reporting period. On June 2, 2014, the Provider filed an individual appeal request which contained six issues. The Medicare Contractor has filed a jurisdictional challenge regarding two of the four remaining issues in the appeal. The challenge addresses Issue No. 1 entitled "Use of Provider's Cost Report Year for Calculation of DSH Percentage," and Issue No. 2 entitled "Disproportionate Share Hospital (DSH) Percentage Determination."

## Medicare Contractor's Position

The Medicare Contractor argues the Board does not have jurisdiction over Issue No. 1 - the Use of the Provider's Cost Report Year for Calculation of DSH Percentage. The Medicare Contractor states the Provider reported its SSI percentage on its as-filed cost report based on the federal fiscal year end of September 30, and now the Provider seeks to change the fiscal year end for which the DSH SSI percentage is reported. The Medicare Contractor notes that the Provider included a protest amount on its cost report for this issue. However, the Medicare Contractor claims the protest is moot as realignment to the Provider's fiscal year end is a Provider election, and the Medicare Contractor does not make this election, nor has it made a final determination regarding this issue.

The Medicare Contractor states the Provider's finalized cost report did not include a DSH SSI Percentage because "because the Provider's allowable DSH percent using the FFY SSI% was too low to

qualify for a DSH payment."[1] The Medicare Contractor indicates the Provider believes it will qualify for the DSH payment if an SSI percentage based upon the Provider's fiscal year end is used, however, the Provider has not provided any documentation supporting this belief. The Medicare Contractor acknowledges that the Provider requested realignment on February 3, 2015, and the request was forwarded to CMS on February 22, 2015. The Medicare Contractor claims the appeal of Use of Provider's Cost Report Year for Calculation of DSH Percentage is premature as no final determination has been made regarding this issue. The Medicare Contractor refers to several similar Board decisions.

The Medicare Contractor also challenges the Board's jurisdiction to hear Issue No. 2 – DSH percentage determination. The Medicare Contractor states the portion of this issue alleging the DSH SSI percentage should be based on the Provider's fiscal year end is not appealable as explained in the arguments addressing Issue No. 1. The Medicare Contractor asserts the portion of this issue alleging corrections are needed based upon the Baystate case and CMS Ruling 1498-R are duplicative of the DSH SSI percentage System Errors issue which was directly appealed in PRRB Case No. 14-3643GC. Because duplicative issues are prohibited by Board Rules, the Medicare Contractor alleges the Board does not have jurisdiction over this portion of the DSH percentage determination issue.

## Provider's Position

The Provider contends the Use of Provider's Cost Report Year for Calculation of DSH Percentage issue is properly before the Board because it has complied with all of the regulatory requirements necessary to request a DSH percentage calculation period realignment. The Provider states it properly submitted its realignment request to the Medicare Contractor on January 30, 2015, and it continues to await the recalculation to which it is entitled. The Provider also asserts it protested the right to a correct realignment of the DSH calculation on its FY 2012 cost report, and the Medicare Contractor adjusted off this item with Audit Adjustment No. 7. Therefore, the Provider argues, the Medicare Contractor has made a final determination regarding this issue.

The Provider states it is challenging the Medicare Contractor's finding that the Provider's disproportionate patient percentage was less than 15 percent with Issue No. 2 – the DSH Percentage determination issue. The Provider believes that once its realignment request pursuant to 42 C.F.R. § 412.106(b)(3) is granted, that it will then qualify for the DSH payment adjustment. Also, the Provider believes that upon recalculation of the disproportionate patient percentage resulting from the correct inclusion of all permissible patient days (the issue in Case No. 14-3643GC), that it will satisfy the 15 percent threshold for the DSH payment adjustment.

## Board Decision

As set for the below, the Board finds that it does not have jurisdiction over Issue No. 1 regarding Use of Provider's Cost Report Year for Calculation of DSH Percentage. The Board also finds that it does not have jurisdiction over Issue No. 2 regarding the DSH Percentage Determination as it is duplicative of the SSI issue in Case No. 14-3643GC.

[1] Medicare Contractor's Jurisdictional Challenge (May 28, 2015) at 2.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

As explained in 42 C.F.R. § 405.1835(a)(1) (2013), a provider may *preserve* its right to claim dissatisfaction with the amount of Medicare payment for the specific items at issue, by either –

> (i) Including a claim for the specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy…

*Issue No. 1 – Use of Provider's Cost Report Year for Calculation of the DSH Percentage*

Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Realignment using the Provider's cost report data is a Provider election. Additionally, there is nothing in the record of this appeal to indicate the Medicare Contractor has made a *final* determination regarding realignment using the Provider's cost report data. The Use of Provider's Cost Report Year for Calculation of DSH Percentage issue is therefore dismissed as the provider did not appeal from a final determination as required by § 405.1835(a).

*Issue No. 2 – DSH Payment Determination*

With regards to Issue No. 2, DSH Payment Determination, the Board finds it has jurisdiction over this issue but that it is duplicative of the SSI accuracy issue located in Case No. 14-3643GC. The Provider states the challenged issue as "[d]id the [Medicare Contractor] err when it calculated the Provider's DSH percentage and concluded that the Provider's DSH percentage was insufficient to entitle the Provider to the DSH adjustment?"[2] The Provider refers to Audit Adjustment Nos. 1, 7 and 13 regarding this issue. The Provider explains that the Medicare Contractor's determination that the Provider did not qualify for the DSH payment was due to calculation of a DSH percentage which did not include "all appropriate days in the applicable calculation in contrast to the plain language of 42 C.F.R. § 412.106." The Provider further stated that this issue pertains to whether or not the Provider is to receive the DSH payment adjustment.

As part of its final position paper ("FPP"), the Provider further narrowed the issue to the SSI fraction claiming that "once its SSI percentage is properly corrected, the Provider will qualify for the additional DSH

[2] Provider's Model Form A – Individual Appeal Request (May 30, 2014), Tab 3 at 1.

payment adjustment in FY 2011." In describing errors with the SSI fraction, the Provider essentially asserts data matching process errors similar to those in the *Baystate Medical Group v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) and the inability to verify that CMS is properly following the data matching process.

The Board finds that Issue No. 1, as narrowed by the FPP, is duplicative of the DSH issue residing in Case No. 14-3643GC which is described in the group appeal request as "[t]he Intermediary erred in calculating the [DSH] Payment by applying the incorrect SSI Percentage to the members of the group. Further, the group appeal request states that "the group members believe that their assertion regarding the incorrect application of the SSI percentage is supported by the holding in the case *Baystate Medical Group v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008)."

Thus, the Providers argument that the SSI percentage must be revised in order for the Provider to qualify, is duplicative of the SSI Percentage challenge in the group issue in Case No. 14-3643GC. The Board dismisses the issue from the individual appeal, as the challenge to the accuracy of the SSI percentage is pending in 14-3643GC. The case remains as two other issues remain.

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

Clayton J. Nix, Esq.
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Gregory H. Ziegler, CPA, CPC-A
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FOR THE BOARD

8/23/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Mail**

Corinna Goron
Healthcare Reimbursement Services, Inc.
c/o Appeals Department
17101 Preston Road, Suite 200
Dallas, TX 75248

**RE:** ***EJR Determination***
HRS FY 2017 Two-Midnight Rule Group Appeals
17-0912GC HRS WKHS 2017 Two Midnight CIRP Group
17-0928GC HRS SCHS FFY 2017 Two Midnight CIRP Group
17-0944GC HRS FFY 2017 Two Midnight Group
17-1005GC HRS Prime Healthcare FFY 2017 Two Midnight CIRP Group
17-1158GC HRS FMOLHS FFY 2017 Two Midnight CIRP Group

Dear Ms. Goron,

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeals and, on June 7, 2019, as required by 42 C.F.R. § 405.1842(c), notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate. The Providers in all of these cases requested EJR on two occasions,[1] but were denied by the Board both times.[2] The EJR requests were denied due to the Providers' failure to articulate what relief they were seeking. Specifically, the Providers appealed the FY 2017 IPPS final rule,[3] but repeatedly referenced the validity of the FY 2016 IPPS Final Rule in their EJR requests. Furthermore, while they argued that an adjustment made in FY 2017 would not make them whole, they did not suggest why it would not, or what relief – in the form of an alternative adjustment or calculation – would suffice. Subsequent to the Board's latest denial of EJR, the Providers in one of the above referenced cases replied to a jurisdictional challenge filed by the Medicare Contractor, in which they clarified what they were challenging with regard to the FY 2017 Final Rule.[4]

The Providers have submitted comments as to whether the Board is without the authority to decide the following legal question:

> Whether the .06 positive adjustment for the FY 2017 Inpatient Prospective Payment System ("IPPS") final rule is invalid for being arbitrary and capricious and promulgated in a procedurally deficient way.[5]

[1] Request for EJR (Dec. 20, 2017) & Revised Request for EJR (Feb. 13, 2018).
[2] Jan. 12, 2018 & March 14, 2018.
[3] 81 Fed Reg. 56761 (Aug. 22, 2016)
[4] Provider's Jurisdictional Response, 1 (Mar. 23, 2018) (PRRB Case No. 17-0928GC).
[5] *Id*.

With regard to the proposed EJR, the Providers support the Board's position that the Board "does not have the authority to declare any final rule substantively invalid (arbitrary and capricious) or procedurally deficient[.]"[6] They confirm that they are challenging the one-time prospective rate increase instituted in the FY 2017 Final Rule because it does not contain any data or reasoning to justify its implementation, and thus violates rulemaking requirements found in the Administrative Procedure Act and Medicare Act.[7] In summary, the Providers believe the Board lacks the authority to decide whether the final rule is procedurally invalid, arbitrary, capricious, and/or outside the statutory authority of CMS and that there are no findings of fact for resolution by the Board.[8]

**Statutory and Regulatory Background**

In the final IPPS rule for FFY 2014,[9] the Secretary of Health and Human Services ("Secretary") indicated that she had expressed concern in the proposed calendar year Outpatient PPS ("OPPS") rule[10] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services.[11] It was observed that the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours had risen from approximately three percent in 2006 to eight percent in 2011.[12] This raised a concern about the financial impact on Medicare beneficiaries who may pay more for the same services as outpatients than they would if they were admitted to the hospital as inpatients.[13]

The Secretary noted that the trend toward outpatient status with extended observation services may have been attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied by the Medicare review contractor. Such claims were denied when the contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS had been advised by stakeholders that the hospitals appeared to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review. They were doing this by treating beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. [14]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary.[15]

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[6] Response to Request for Additional Information/EJR Request, 1 (July 3, 2019).
[7] *Id.* at 2-3.
[8] *Id.* at 5.
[9] 78 Fed. Reg. 50495 (Aug. 19, 2013).
[10] 77 Fed. Reg. 45061, 45155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68210, 68426-33 (Nov. 15, 2012).
[11] 78 Fed. Reg. at 50906.
[12] *Id.* at 50907.
[13] *Id.*
[14] *Id.*
[15] *Id.*

The Secretary also reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. At the time, the Medicare Benefit Policy Manual stated that, once the reason for the observation care is resolved, the typical decision to admit a beneficiary as an inpatient can usually be made within 24 hours, and most within 48 hours. It also stated that an overnight stay may be a factor in the admission decision. Physicians were to use the 24-hour or overnight period as a benchmark, that is, patients who were expected to need care for 24 hours or overnight should have been admitted as inpatients. Generally, a beneficiary was considered an inpatient if formally admitted with the expectation that he or she would remain in the hospital overnight, regardless of whether there was a later transfer or discharge resulting in no overnight patient stay. It explained that only rare and exceptional cases require reasonable and necessary observation services which span more than 48 hours. Length of stay, however, is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[16]

In the FFY 2014 IPPS proposed rule,[17] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing two midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment. This became known as the "2-Midnight Rule." Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the two midnight timeframe).[18]

The 2-Midnight Rule

In the final 2014 IPPS rule, the Secretary pointed out that CMS had established policy that recognized there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule adopted the 2-Midnight Rule, providing instructions that gave a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[19]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designated services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects a stay that crosses two midnights and admits the beneficiary based on that expectation.[20]

The Secretary's actuaries estimated that the 2-Midnight Rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase

[16] *See* 78 Fed. Reg. at 50907-08 (*citing* The Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 6, § 20.6 & Chapter 1, § 10).
[17] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).
[18] 78 Fed. Reg. at 50908.
[19] 78 Fed. Reg. at 50944.
[20] *Id.*

in hospital inpatient encounters due to some encounters spanning more than two midnights moving from OPPS to IPPS and some encounters of less than two midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, causing a net shift of 40,000 encounters to inpatient.[21] This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay inpatient encounters to outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these outpatient encounters would be approximately thirty percent of the per encounter payments for the inpatient encounters.[22]

In light of the impact of the 2-Midnight Rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-Midnight Rule. Consequently, the standardized amount was reduced by 0.2 percent.[23] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[24]

In the proposed FY 2016 OPPS rule, the Secretary noted that the data was, at that point, consistent with the assumptions used to develop the 0.2 percent adjustment estimate. Long outpatient stays and very short inpatient stays were declining, while two to four day inpatient stays increased.[25] As time went on, however, the impact of the shift between inpatient and outpatient encounters proved to be more complex than anticipated, and in the proposed FY 2017 IPPS rule, the Secretary proposed removing the reduction beginning in FY 2017.[26] The Secretary also proposed a one-time prospective increase of 0.6 percent in FY 2017 to address the effect of the 0.2 percent reductions in FYs 2014, 2015, and 2016.[27] The 0.2 percent reduction was removed indefinitely, and the one-time increase of 0.6 percent was adopted for FY 2017 in the FY 2017 IPPS Final Rule.[28]

**Providers' Position**

The Providers note CMS' original estimate that the 2-Midnight Rule would increase IPPS operating and capital expenditures by approximately $220 million. The Providers argue, however, that hospitals will not receive any of this increase because CMS attempted to offset this amount by applying a 0.2 percent reduction adjustment to the operating IPPS standardized amounts.

The Providers maintain the decision to impose a $220 million payment cut is arbitrary and capricious because it relies on faulty assumptions and improperly excluded relevant data. They also state that the cut is not adequately explained: while the FY 2014 final rule estimated an approximate net gain of

[21] *Id.* at 50952.
[22] *Id.* at 50952-53.
[23] *Id*.
[24] *Id.* at 50990.
[25] 80 Fed. Reg. 39199, 39370 (July 8, 2015).
[26] 81 Fed. Reg. 24945, 25140 (April 27, 2016).
[27] *Id*.
[28] 81 Fed Reg. 56761, 57059 (Aug. 22, 2016).

40,000 inpatient stays, it does not give much detail as to how CMS arrived at this estimate, such as the number of claims that were examined or how the data was used.[29]

Faulty Assumptions

The Providers argue that CMS makes faulty assumptions that claims will be billed and actually paid as outpatient or inpatient based on the bright line of whether the stay lasted two midnights. The Providers do not believe that these assumptions are valid, especially in light of the Part B inpatient policy, which assumes the denial of inpatient claims will happen and allows hospitals to re-bill them as outpatient claims. Further, hospitals may still be concerned that short stays, including stays spanning two midnights, will be denied under Part A and that they will be unable to re-bill under Part B in the twelve month window, so they may bill some of these stays under Part B to begin with. Also, the hospital may decide not to bill under Part A, despite having admitted the patient, because it may believe that the medical record does not contain sufficient documentation to explain why the ordering physician had a reasonable explanation that the beneficiary was expected to cross two midnights.[30]

Improper Exclusion of Relevant Data

The Providers maintain where Part A payment is allowed, it would increase the total amount of Part A payment, despite the 2-Midnight Rule. However, if Part A payment is denied, not only would the total amount of Part A payment not increase, but there likely would not be Part B payment to effect a partial offset of the total amount of Part A payment because the hospitals likely will be unable to re-bill under Part B within twelve months. The Providers note that, in arriving at its estimate, CMS did not consider medical cases but, instead, claims containing medical MS-DRGs were excluded. The Providers argue the FY 2014 IPPS final rule is procedurally invalid for failing to have notified commenters that medical MS-DRGs were being excluded from the analysis of to what extent outpatient cases would shift to inpatient and vice versa and is also substantively invalid because it makes no sense to have excluded the medical MS-DRGs. The Providers note that the explanation given by CMS on December 1, 2015, after publishing a notice in the Federal Register with an opportunity for comment,[31] as to why it did not consider medical cases when estimating a net increase in 40,000 inpatient cases is flawed and unconvincing.[32] The Providers assert that CMS has not adequately explained why it considered only surgical cases and excluded from consideration medical cases when concluding that there would be a net shift in inpatient cases.[33]

The Providers contend the decision to impose a $220 million payment cut is arbitrary and capricious because it does not adequately take into account the payment reduction made by the Part B inpatient policy and that, even if the 2-Midnight Rule does result in increased Medicare payments in the vicinity of $220 million per year, CMS projects that the closely related inpatient Part B policy reduces Medicare payments by almost a billion dollars a year, yet there is no increase in the payment rates account for this reduction.[34] The Providers maintain the decision to impose a $220 million payment cut is arbitrary and capricious because it does not provide any mechanism for making adjustments to, or reversing the

[29] Providers' Revised EJR Request at 6-7 (Feb. 9, 2018).
[30] *Id.* at 8-9.
[31] 80 Fed. Reg. 75107.
[32] Providers' Revised EJR Request at 10-11 (Feb. 9, 2018).
[33] *Id.* at 11-12.
[34] *Id*. at 12.

effects of, the payment cut if CMS' estimate is incorrect, and that the estimate of additional $220 million IPPS expenditures is highly speculative.[35]

Additional Arguments

The Providers maintain that the decision to imposes a $220 million payment cut is otherwise not in accordance with law because CMS did not have statutory authority to impose an across the board payment reduction. The Providers maintain that the authority relied upon by CMS, its exceptions and adjustments authority, under 42 U.S.C. §§ 1395ww(d) and 1395ww(g) does not permit CMS to make across the board decreases in payment rates due to hospitals. The Providers argue the exceptions and adjustments clause permits CMS to make payment adjustments only to specific hospitals or specific types of hospitals rather than payment adjustments to all hospitals.[36]

The Providers acknowledged that in the FY 2017 IPPS final rule, CMS abandoned the 0.2 percent payment reduction, and made a one-time positive adjustment of 0.6 percent in order to reverse the effects of the 0.2 percent payment cut for FYs 2014, 2015 and 2016. The Providers argue the one-time positive adjustment of 0.6 percent will not make them whole for the reductions imposed for FYs 2014-2016 because the number of discharges for FY 2017 likely will not equal the average number of discharges for the period FY 2014-2016 due to the recent trend of declining admissions. They also note that the FY 2014 rule remains in effect.[37]

The Providers contend that the Department of Justice ("DOJ") has taken the position that the FY 2017 final rule supersedes the FY 2014 IPPS final rule and that any further relief beyond the .06 one-time positive adjustment must be obtained through a successful challenge to the FY 2017 final rule. The Providers argue DOJs position is exactly the opposite of the Medicare Contractor's position in this case. The Providers maintain that they are not seeking a total reversal of the .06 positive adjustment through their challenge to the FY 2017 final rule, rather only the shortfall between what they are paid under the .02 positive adjustment and what they should be paid if CMS had simply reversed the effects of the .02 percent payment cut for each of FYs 2014-2016.[38]

The Providers argue the Board does have jurisdiction, but does not, however, have the authority to declare the .02 decrease or the .06 positive adjustment in the FY 2017 IPPS rates invalid. The Providers maintain because the Board is bound to comply with the decrease in FY 2017 IPPS rates, the Board lacks the authority to decide whether the FY 2017 final rule is procedurally invalid, arbitrary, capricious, and outside the statutory authority of CMS. The Providers have asserted, therefore, that EJR is appropriate.[39]

[35] *Id.* at 15.
[36] *Id.* at 15-16.
[37] *Id.* at 12.
[38] Providers' Jurisdictional Response at 2 (Mar. 23, 2018). *See also* Response to Request for Additional Information/EJR Request (July 3, 2019).
[39] Providers' Jurisdictional Response at 2.

**Medicare Contractor's Position**

The Medicare Contractor, in its jurisdictional challenge, argues that the appeal here is premature, resulting in a lack of subject matter jurisdiction for the Board.[40] It also argues that the amount in controversy cannot be established, especially in light of the FY 2017 correction implemented by CMS.[41] The Medicare Contractor believes that the Board lacks jurisdiction in this case, but that, if the Board does find jurisdiction, that the Board lacks the authority to grant the relief sought by the Providers.[42]

**Decision of the Board**

The Board has reviewed the Providers' Group Appeal Requests and comments regarding the proposed own motion EJR determination. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a). With respect to jurisdiction, the Board concludes that the Providers timely appealed from the Federal Register and the amount in controversy exceeds the $50,000 threshold necessary for each group appeal.[43]

The Medicare Contractor suggests in its Jurisdictional Challenge that the amount in controversy cannot be established, especially in light of the remedial 0.6 percent positive adjustment to the IPPS rates in FY 2017. The amount in controversy requirement set forth in 42 U.S.C. § 1395oo(a)(2), however, is nothing more than a jurisdictional provision, and no extensive fact-finding is necessary to determine that it exceeds the jurisdictional threshold.[44] Indeed, the amount in controversy is normally determined from the face of the pleadings.[45] Federal courts have found the amount in controversy requirement set forth in 42 U.S.C. § 1395oo(a)(2) to be comparable to the amount in controversy provision for diversity cases under 28 U.S.C. § 1332, for which the Supreme Court has held that the sum claimed by the plaintiff controls if the claim is apparently made in good faith.[46] The Board finds that the amounts claimed by the Providers were made in good faith.

Consequently, the Board has determined that it has jurisdiction over these group appeals. This issue involves a challenge to the validity of a provision found in the proposed and final rules published for FY 2017 in the Federal Register. Further, the Board finds that it lacks the authority to decide the legal question of whether the .06 positive adjustment to the FY 2017 IPPS rates as finalized in the FY 2017 IPPS final rule published on August 22, 2016 ("FY 2017 IPPS Final Rule") is invalid for being arbitrary and capricious and promulgated in a procedurally deficient way.

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[40] Medicare Administrative Contractor's Jurisdictional Challenge, 1 (Feb. 27, 2018).
[41] *Id.* at 1, 3.
[42] *Id.* at 3.
[43] *See* 42 C.F.R. § 405.1837(a).
[44] *Russell-Murray Hospice, Inc. v. Sebelius*, 724 F. Supp. 2d 43, 56 (D.D.C. 2010).
[45] *Beacon Healthcare Services, Inc. v. Leavitt*, 629 F.3d 981, 984 (9th Cir. 2010).
[46] *See Infinity Care of Tulsa v. Sebelius*, 2011 WL 778111, 3 (N.D. Okla. 2010). *See also Russell-Murray Hospice, Inc.*, 724 F. Supp. 2d at 56 ("To require the PRRB to gather data and perform a detailed calculation of the specific amount in controversy simply to establish its jurisdiction to hear an appeal would represent a significant departure from the established scope of jurisdictional fact-finding . . ."); *IHG Healthcare v. Sebelius*, 717 F. Supp. 2d 696, 706 (S.D. Tex. 2010) ("When the amount in controversy is put in issue, a federal court generally asks whether it is facially apparent from the complaint that the plaintiff seeks recovery in an amount greater than the jurisdictional minimum. . . . But the court can find no reason, or authority, for requiring the PPRB to undertake more arduous fact-finding in evaluating its jurisdiction[.]" (citations omitted).

The Board finds that:

1) It has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding the decrease in IPPS payments due to the 2-Midnight Rule and the positive adjustment implemented in FY 2017, 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 whether the .06 positive adjustment to FY 2017 IPPS rates as finalized in FY 2017 IPPS Final Rule is invalid for being arbitrary and capricious and promulgated in a procedurally deficient way.

Accordingly, the Board finds that the 2-Midnight Rule issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Board Members Participating:

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For the Board:

8/27/2019

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Justin Lattimore, Novitas Solutions, Inc. (J-H)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Via Electronic Mail**

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**RE:** ***EJR Determination***
15-2551GC McLaren Health Care 2013-2014 DSH Medicare Part C Days Group
16-2150G Hall Render 2014 DSH Medicare/Medicaid Part C Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") is in receipt of your letter dated August 9, 2019 responding to the Board's second request for additional information regarding Case Nos. 15-2551GC and 16-2150G. The Providers in these cases have fiscal years ending after October 1, 2013[1], the date on which the Secretary[2] effectuated the readoption of the regulation, 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). The readoption effects discharges on or after October 31, 2013. In your response, you confirm that, notwithstanding this readoption, the Providers in the groups are challenging the Medicare program's handling of their Part C days in their DSH calculations for the periods *both* prior to *and* following the October 1, 2013 effective date for this readoption. Accordingly, as set forth below, the Board is denying the Provider's request for expedited judicial review ("EJR") because the Board has determined that Case Nos. 15-2551GC and 16-2150G are not properly structured and are out of compliance with 42 C.F.R. § 405.1837(a). The Providers has ***30 days from the date this letter is signed*** (*i.e.*, by Friday, September 27, 2019) to request bifurcation or the Board may dismiss this case.

By way of background, the Secretary announced a new policy in the final rule for the FFY 2005 inpatient prospective payment system ("IPPS") published on August 11, 2004, specifying that Medicare Part C days would be counted in the SSI fraction (also referred to as the "Medicare fraction") for discharges on or after October 1, 2004 (the "FFY 2005 Part C Days SSI Policy"). The following issue in these appeals disputes the application of this policy:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment

[1] In Case No. 15-2551GC, only provider number 5 McLaren Port Huron (Provider no. 23-0216, FYE 6/30/2014) straddles FFYs 2013 and 2014.
[2] of the Department of Health and Human Services.

("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.[3]

Although the FFY 2005 Part C Days SSI Policy 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 codifying this policy at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[4] Thus, as a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004.[5]

Multiple providers subjected the FFY 2005 Part C Days SSI Policy to much litigation by challenging these regulatory provisions under the Administrative Procedure Act ("APA"). In the decision for *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[6] the U.S. Circuit Court for the District of Columbia ("D.C. Circuit") vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy[7] and the subsequent regulations issued in the FFY 2008 IPPS final rule[8] codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[9] However, the Secretary has not acquiesced to that decision.

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[3] Providers' EJR request at 1.

[4] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007). 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). *Id.* at 47411.

[5] 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." 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).

[6] 746 F. 3d 1102 (D.C. Cir. 2014).

[7] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[8] 72 Fed. Reg. 47130, 47384, 47411 (Aug. 22, 2007) (announcing "technical corrections" to the regulatory language at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) consistent with the change adopted in the FFY 2005 IPPS final rule). 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." 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).

[9] *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.").

Subsequently, on November 15, 2012, the D.C. Circuit issued its decision in *Allina Healthcare Services v. Sebelius* ("*Allina II*") finding in favor of the providers.[10] Following this decision, "in an abundance of caution," the Secretary published a proposed rule on May 10, 2013 to readopt the regulations codifying the FFY 2005 Part C Days Policy.[11] In the final rule published on August 19, 2013, the Secretary readopted its then-existing regulations at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) without "any change to the regulation text because the current text reflects the policy."[12] This readoption was effective for discharges occurring ***on or after October 1, 2013*** and will be referred to as the "FFY 2014 Readopted Part C Days Policy."[13]

Some or all of the Providers in the current cases have fiscal years that straddle October 1, 2013 and, as a result, have a portion of their fiscal year falling outside of the timeframe covered by Allina I. Specifically, some or all of the Providers in the groups have a fiscal years ending after October 1, 2013, which falls outside timeframe covered by *Allina I*. In this regard, the Board notes that, in the appeal request filed in this case, the Representative summaries the Part C issue essentially as follows:

> Providers . . . assert that any Medicare Advantage (MA or Medicare Part C) Days that are also Dual Eligible (DE) Days cannot be counted in the Medicare ratio . . . primarily because the CMS regulation requiring such inclusion in the Medicare ratio is invalid, therefore these DE-MA days must be counted in the Medicaid fraction.

As such, for that part of their FYE that is after October 1, 2013, the Providers cannot obtain their requested relief (counting of any days for discharges occurring after October 1, 2013 in the Medicaid fraction as opposed to the SSI fraction) because ***those days*** *must be counted in the SSI fraction FFY 201**4*** pursuant to the FFY 2014 Readopted Part C Days Policy.[14]

Therefore, since the there are multiple legal issues contained in Case Nos. 15-2551GC and 16-2150G (that may not necessarily pertain to all the providers in both groups), the groups currently are not in compliance with requirements of 42 C.F.R. § 405.1837. In particular, § 405.1837(a) specifies, in pertinent part, that there can only be one legal issue in a group appeal and that legal issue must be common to all the participants in the group:

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[10] 904 F. Supp. 2d 75 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[11] 78 Fed. Reg. 27846, 27578 (May 10, 2013).
[12] 78 Fed. Reg. 50496, 50618, 50620 (Aug. 19, 2013).
[13] *Id.* at 50496 (stating "These changes will be applicable to discharges occurring on or after October 1, 2013, unless otherwise specified in this final rule").
[14] Similarly, the Board recognizes that each of the Providers had the SSI fraction at issue based on FFY 2013 (*i.e.*, October 1, 2012 to September 30, 2013. However, the Medicaid fraction is ***not*** based on the federal fiscal year ("FFY") but rather it is based on the hospital's fiscal year which in this case is January 1, 2013 to December 31, 2013.

> (a) Right to Board hearing as part of a group appeal: Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, ***only if*** - . . .
>
> (2) The matter at issue in the group appeal involves ***a single question*** of fact or interpretation of law, regulations, or CMS Rulings *that is* ***common to <u>each</u> provider*** *in the group*; . . . .[15]

Similarly, § 405.1837(f) specifies, in pertinent part, that the Board may not consider more than a single question of fact or law "common to each provider in the [group] appeal" and that, in those instances where the group appeal request involves more than one such question "common to each provider," there must be a bifurcation:

> The Board may not consider, in one group appeal, more than one question of fact, interpretation of law, regulations, or CMS Rulings that is *common to* ***each*** *provider* in the appeal. If the Board finds jurisdiction over a group appeal hearing request under § 405.1840 of this subpart -
>
> (i) The Board must determine whether the appeal involves specific matters at issue that raise more than one factual or legal question common to each provider; and
>
> (ii) When the appeal is found to involve more than one factual or legal question *common to* ***each*** *provider*, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case.[16]

As Case Nos. 15-2551GC and 16-2150G are not properly structured and are out of compliance with § 405.1837(a), the Board hereby denies the request for EJR for these cases.

Since Case Nos. 15-2551GC and 16-2150G include two legal issues, the Representative will need to establish another appeal and supply appropriate bifurcation and transfer requests for the providers appealing the period after October 1, 2013 ***within the next 30 days*** **of the date of this letter** (*i.e.*, by Friday, September 27, 2019). However, if the Representative fails to take those actions by the deadline, the Board may dismiss Case Nos. 15-2551GC and 16-2150G.

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[15] (Emphasis added.)
[16] (Emphasis added.)

Once the new group is established and the Schedules of Providers (with the associated jurisdictional documents) covering the period after October 1, 2013 has been submitted, an EJR for the Providers who are challenging the *period **prior to** October 1, 2013* can be re-filed in these appeals.

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FOR THE BOARD:

8/28/2019

X Clayton J. Nix

Clayton J. Nix
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**Via Electronic Delivery**

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**RE:** ***Expedited Judicial Review Determination***
16-2081GC Tenet FY 2014 DSH pre-10/1/2-13 Medicaid Fraction Medicare Advantage Days Group
16-2084GC Tenet FY 2014 DSH SSI Fraction Medicare Advantage Days Group[1]

Dear Mr. Keough:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 30, 2019 request for expedited judicial review ("EJR") (received July 31, 2019) for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

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

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

[1] Case No. 16-2031GC, Tenet FY 2014 DSH pre-10/1/2013 Medicaid Fraction Medicare Advantage Days Group, has a corresponding appeal pending for the post-10/1/2013 period, case number 16-2082GC. Although Case No. 16-2084GC, Tenet FY 2014 DSH SSI Fraction Medicare Advantage Days Group, is not labeled as a pre-10/1/2013 appeal, Tenet has a corresponding appeal pending for the 10/1/2013 in Case No. 17-1800GC, Tenet 2014 Post 10/1/2013SSI Fraction Medicare Fraction Medicare Advantage Days Group. Consequently, the Board's decision in both cases will apply to the pre 10/1/2013 period.
[2] "SSI" is the acronym for "Supplemental Security Income."
[3] Providers' EJR Request at 4.
[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[13]

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

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[14]

Medicare Advantage Program

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

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

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

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

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [19]

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

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

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

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[22]

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Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

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

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

[21] 69 Fed. Reg. at 49099.

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[26] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[27] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[28] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[29] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[30] Once again, the Secretary has not acquiesced to this decision.

**Providers' Request for EJR**

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

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

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

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

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

## Decision of the Board

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

### Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2014 for the period prior to 10/1/2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen.*[33] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming

[31] 69 Fed. Reg. at 49,099.
[32] *Allina* at 1109.
[33] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[34]

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

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[38] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

*A. Jurisdictional Determination On Certain Specific Individual Participants*

At the outset, the Board notes that a Board finding of jurisdiction is a prerequisite to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority request "[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision,"[39] including documentation relating to jurisdiction.

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[34] *Bethesda at 1258-59.*
[35] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[36] 201 F. Supp. 3d 131 (D.D.C. 2016)
[37] *Banner* at 142.
[38] See 42 C.F.R. § 405.1889(b)(1) (2008).
[39] 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which included a decision on both jurisdiction and the EJR request).

Similarly, the regulations governing group appeals specify that jurisdiction "may be raised at any time."[40]

The Providers listed below appealed a revised NPR that did not adjust the Part C issue as required for Board jurisdiction, rather it was an appeal of an SSI realignment. Those Providers are:

*Case No. 16-2081GC*

#11 Twin Cities Community Hospital, Inc. (Provider No. 05-0633, FYE 5/31/2014)
#14 Hialeah Hospital (Provider No. 10-0053, FYE 5/31/2014)
#16 Good Samaritan Medical Center (Provider No. 10-0287, FYE 5/31/2014)
#18 St. Mary's Medical Center (Provider No. 10-0288, FYE 5/31/2014)
#24 Piedmont Medical Center (Provider No. 42-0002, FYE 5/31/2014)
#33 Doctors Hospital at White Rock Lake (Provider No. 45-0678, FYE 5/31/2014)
#35 Lake Pointe Medical Center (Provider No. 45-0742, FYE 5/31/2014)

*Case No. 16-2084GC*

#7 Sierra Vista Hospital (Provider No. 05-0506, FYE 5/31/2014)
#9 JFK Memorial Hospital (Provider No. 05-0534, FYE 5/31/2014)
#11 Los Alamitos Medical Center (Provider No. 05-0551, FYE 5/31/2014)
#14 Placentia Linda Hospital (Provider No. 05-0589, FYE 5/31/2014)
#16 Twin Cities Community Hospital, Inc. (Provider No. 05-0633, FYE 5/31/2014)
#19 Hialeah Hospital (Provider No. 10-0053, FYE 5/31/2014)
#21 Good Samaritan Medical Center (Provider No. 10-0287, FYE 5/31/2014)
#23 St. Mary's Medical Center (Provider No. 10-0288, FYE 5/31/2014)
#29 Piedmont Medical Center (Provider No. 42-0002, FYE 5/31/2014)
#38 Doctors Hospital at White Rock Lake (Provider No. 45-0678, FYE 5/31/2014)
#40 Lake Pointe Medical Center (Provider No. 45-0742, FYE 5/31/2014)

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

The Providers, above, requested that their SSI percentages be recalculated from the federal fiscal year to their respective cost reporting years. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used.[41] The

[40] 42 C.F.R. 405.1837(e)(2) states: "*The Board may make jurisdictional findings* under § 405.1840 ***at any time***, including, but not limited to, following a request by the providers for the jurisdictional findings. The providers may request jurisdictional findings by notifying the Board in writing that the group appeal is fully formed, or that the providers believe they have satisfied all of the requirements for a group appeal hearing request, and the Board may proceed to make jurisdictional findings."

[41] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). Similarly, CMS' policy on Part C days was set in the

realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the September 30 FFY.[42]

The regulation, 42 C.F.R. § 405.1889 (2012), addresses provider rights to appeal revised determinations and states, in pertinent part, that:

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

Since the revised NPRs for the above-referenced Providers did not adjust the Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that is lacks jurisdiction over their revised NPRs and hereby dismisses the appeals of the revised NPRs for the Providers listed above. Because jurisdiction over a provider is a requisite to granting a request for EJR, the Board hereby denies these Providers' request for EJR involving their revised NPR from Case Nos. 16-2081GC and 16-2084GC.[43] Notwithstanding, with the exception of #11 Twin Cities Community Hospital in Case No. 16-2081GC, the above-listed Providers appealed their original NPR and their original NPR appeals remain pending in these cases.

*B. Jurisdictional Determination for Remaining Participants*

The Board has determined that the remaining participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[44] The appeals were timely filed. Based on the

FFY 2005 Final Rule and is incorporated into and reflected in this data matching process. *See* 75 Fed. Reg. at 50276, 50285-6.

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

[43] *See* 42 C.F.R. § 405.1842(a).

[44] *See* 42 C.F.R. § 405.1837.

above, the Board finds that it has jurisdiction over the above-captioned appeal and the underlying, remaining providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeal in this EJR request involves the cost reporting period 2014 *but only for the period prior to 10/1/2013*.[45] Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[46] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[47] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year[48] and that the remaining participants in this group appeal are entitled to a hearing before the Board;

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

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

8/28/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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**Via Electronic Mail**

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**RE: EJR Determination**
16-1519GC Premier Health Partners 2013 DSH Medicare/Medicaid Part C Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") is in receipt of your letter dated July 30, 2019 responding to the Board's second request for additional information regarding Case No. 16-1519GC. Each of the Providers this case has a fiscal year ending on December 31, 2013, which straddles October 1, 2013 the date on which the Secretary[1] effectuated the readoption of the regulation, 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). The readoption effects discharges on or after October 31, 2013. In your response, you confirm that, notwithstanding this readoption, the Providers in the group are challenging the Medicare program's handling of their Part C days in their DSH calculations for the periods *both* prior to *and* following this readoption. Accordingly, as set forth below, the Board is denying the Provider's request for expedited judicial review ("EJR") because the Board has determined that Case No.16-1519GC is not properly structured and is out of compliance with 42 C.F.R. § 405.1837(a). The Provider has ***30 days from the date this letter is signed*** (*i.e.*, Monday, by September 30, 2019) to request bifurcation or the Board may dismiss this case.

By way of background, the Secretary announced a new policy in the final rule for the FFY 2005 inpatient prospective payment system ("IPPS") published on August 11, 2004, specifying that Medicare Part C days would be counted in the SSI fraction (also referred to as the "Medicare fraction") for discharges on or after October 1, 2004 (the "FFY 2005 Part C Days SSI Policy"). The following issue in these appeals disputes the application of this policy:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.[2]

[1] of the Department of Health and Human Services.
[2] Providers' EJR request at 1.

Although the FFY 2005 Part C Days SSI Policy 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 codifying this policy at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[3] Thus, as a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004.[4]

Multiple providers subjected the FFY 2005 Part C Days SSI Policy to much litigation by challenging these regulatory provisions under the Administrative Procedure Act ("APA"). In the decision for *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[5] the U.S. Circuit Court for the District of Columbia ("D.C. Circuit") vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy[6] and the subsequent regulations issued in the FFY 2008 IPPS final rule[7] codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[8] However, the Secretary has not acquiesced to that decision.

Subsequently, on November 15, 2012, the D.C. Circuit issued its decision in *Allina Healthcare Services v. Sebelius* ("*Allina II*") finding in favor of the providers.[9] Following this decision, "in

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[3] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007). 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). *Id.* at 47411.

[4] 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." 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).

[5] 746 F. 3d 1102 (D.C. Cir. 2014).

[6] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[7] 72 Fed. Reg. 47130, 47384, 47411 (Aug. 22, 2007) (announcing "technical corrections" to the regulatory language at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) consistent with the change adopted in the FFY 2005 IPPS final rule). 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." 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).

[8] *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.").

[9] 904 F. Supp. 2d 75 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

an abundance of caution," the Secretary published a proposed rule on May 10, 2013 to readopt the regulations codifying the FFY 2005 Part C Days Policy.[10] In the final rule published on August 19, 2013, the Secretary readopted its then-existing regulations at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) without "any change to the regulation text because the current text reflects the policy."[11] This readoption was effective for discharges occurring ***on or after October 1, 2013*** and will be referred to as the "FFY 2014 Readopted Part C Days Policy."[12]

All of the Providers in the current case have fiscal years that straddle October 1, 2013 and, as a result, have a portion of their fiscal year falling outside of the timeframe covered by *Allina I.* Specifically, as all of the Providers in the group have a fiscal year ending December 31, 2013, only the last quarter of 2013 (*i.e.*, October 1, 2013 through December 31, 2013) falls outside of the timeframe covered by *Allina I.* In this regard, the Board notes that, in the appeal request filed in this case, the Representative summaries the Part C issue essentially as follows:

> Providers . . . assert that any Medicare Advantage (MA or Medicare Part C) Days that are also Dual Eligible (DE) Days cannot be counted in the Medicare ratio . . . primarily because the CMS regulation requiring such inclusion in the Medicare ratio is invalid, therefore these DE-MA days must be counted in the Medicaid fraction.

As such, for the last quarter of their fiscal year, the Providers cannot obtain their requested relief (counting of any days for discharges occurring from October 1, 2013 through December 31, 2013 in the Medicaid fraction as opposed to the SSI fraction) because ***those days*** *must be counted in the SSI fraction FFY 201**4*** pursuant to the FFY 2014 Readopted Part C Days Policy.[13]

Therefore, since the there are multiple legal issues contained in Case No. 16-1519GC, the group currently is not in compliance with requirements of 42 C.F.R. § 405.1837. In particular, § 405.1837(a) specifies, in pertinent part, that there can only be one legal issue in a group appeal and that legal issue must be common to all the participants in the group:

> (a) Right to Board hearing as part of a group appeal: Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, with

[10] 78 Fed. Reg. 27846, 27578 (May 10, 2013).
[11] 78 Fed. Reg. 50496, 50618, 50620 (Aug. 19, 2013).
[12] *Id.* at 50496 (stating "These changes will be applicable to discharges occurring on or after October 1, 2013, unless otherwise specified in this final rule").
[13] Similarly, the Board recognizes that each of the Providers had the SSI fraction at issue based on FFY 2013 (*i.e.*, October 1, 2012 to September 30, 2013. However, the Medicaid fraction is ***not*** based on the federal fiscal year ("FFY") but rather it is based on the hospital's fiscal year which in this case is January 1, 2013 to December 31, 2013.

> respect to a final contractor or Secretary determination for the provider's cost reporting period, ***only if*** - . . .
>
> (2) The matter at issue in the group appeal involves ***a single question*** of fact or interpretation of law, regulations, or CMS Rulings *that is* ***common to <u>each</u> provider*** *in the group*; . . . .[14]

Similarly, § 405.1837(f) specifies, in pertinent part, that the Board may not consider more than a single question of fact or law "common to each provider in the [group] appeal" and that, in those instances where the group appeal request involves more than one such question "common to each provider," there must be a bifurcation:

> The Board may not consider, in one group appeal, more than one question of fact, interpretation of law, regulations, or CMS Rulings that is *common to* ***each*** *provider* in the appeal. If the Board finds jurisdiction over a group appeal hearing request under § 405.1840 of this subpart -
>
> (i) The Board must determine whether the appeal involves specific matters at issue that raise more than one factual or legal question common to each provider; and
>
> (ii) When the appeal is found to involve more than one factual or legal question *common to* ***each*** *provider*, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case.[15]

As Case No. 16-1519GC is not properly structured and is out of compliance with § 405.1837(a), the Board hereby denies the request for EJR for this case.

As Case No. 16-1519GC includes two legal issues, the Representative will need to establish another appeal and supply appropriate bifurcation and transfer requests for the providers appealing the first quarter of the FFY 2014 period ***within the next 30 days of the date of this letter*** (*i.e.*, by Monday, September 30, 2019). However, if the Representative fails to take those actions by the deadline, the Board may dismiss Case No. 16-1519GC.

Once the new group is established and the Schedules of Providers (with the associated jurisdictional documents) covering the first quarter of FFY 2014 (*i.e.*, October 1, 2013 to

[14] (Emphasis added.)
[15] (Emphasis added.)

December 31, 2013) has been submitted, an EJR for the Providers who are challenging the *period **prior to** October 1, 2013* can be re-filed in this appeal.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Robert A. Everts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

8/29/2019

X Clayton J. Nix

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

cc: Judith Cummings, CGS Administrators
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

**Electronic Delivery**

Joseph Glazer, Esq.
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Princeton, NJ 08540

**RE:** ***Part C Days Medicaid and Medicare Proxy Groups – PRRB Own Motion Expedited Judicial Review Determination***

14-0981G Glazer 2006 DSH/Medicare Part C Days - Medicare Proxy Group
14-0983G Glazer 2006 DSH/Medicare Part C Days - Medicaid Proxy Group
14-0966G Glazer 2007 DSH/Medicare Part C Days - Medicaid Proxy Group
14-0971G Glazer 2007 DSH/Medicare Part C Days - Medicare Proxy Group
14-3146G Glazer 2008 DSH Medicare Part C Days - Medicaid Proxy Group
14-3148G Glazer 2008 DSH Medicare Part C Days - Medicare Proxy Group

Dear Mr. Glazer:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeals and, on July 17, 2019, as required by 42 C.F.R. § 405.1842(c), notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above referenced CIRP group cases. The Providers and the Medicare Contractor have also submitted comments as to whether the Board is without the authority to decide the following legal questions[1]:

> Whether the Intermediary wrongfully include the Provider's Medicare part C days in the Medicare Proxy used to calculate the Provider's allowable Medicare disproportionate share payment.[2]
>
> And,
> Whether the Intermediary failed to include all of the Provider's Medicare part C days in the numerator of the Medicaid Proxy used to calculate the Provider's allowable Medicare disproportionate Share hospital (DSH) payment.[3]

Both the Provider and the Medicare Contractor are in agreement that the Board does not have the authority to grant the relief sought.

[1] The Provider's comments were received on August 12th, 2019 and the Medicare contractor's comments were received on August 14th, 2019.
[2] Request for Hearing, Issue Statement, at Ex. 2 (Nov. 25, 2013), 14-0981G.
[3] Request for Hearing, Issue Statement, at Ex. 2 (Nov. 25, 2013), 14-0983G.

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[14]

Medicare Advantage Program

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

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

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

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

> including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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

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

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

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

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

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

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

> *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.*[22]

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

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

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

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

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

**Board's Consideration for Own Motion EJR**

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[31] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[32] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

**Decision of the Board**

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

*Jurisdiction for the Group Participants*

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006 through 2008.

[28] 863 F.3d 937 (D.C. Cir. 2017).
[29] *Id.* at 943.
[30] *Id.* at 943-945.
[31] 69 Fed. Reg. at 49099.
[32] *Allina* at 1109.

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

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

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

The Board has determined that the remaining participants' appeals involved with the instant EJR are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. Each Provider appealed from an original NPR. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[38] and that the

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[33] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[34] *Bethesda*, 108 S. Ct. at 1258-59.
[35] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[36] 201 F. Supp. 3d 131 (D.D.C. 2016)
[37] *Id.* at 142.
[38] *See* 42 C.F.R. § 405.1837.

appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the referenced appeals and the participants.

*Board's Analysis Regarding the Appealed Issue*

The appeals in these EJR requests involve the fiscal years 2006 through 2008 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[39] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[40] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

*Board's Decision Regarding the Own Motion EJR*

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants its Own Motion EJR for the issue and the subject years, except for any specific participants noted above. The participants have 60 days from the receipt of this decision to

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

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

**Board Members Participating:**

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

**For the Board:**

8/30/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Wilson Leong, Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**RE:** ***Part C Days Medicaid and Medicare Proxy Groups – PRRB Own Motion Expedited Judicial Review Determination***
14-1281GC Capital Health 2006 Medicare Proxy Part C Days CIRP
14-1282GC Capital Health 2006 Medicaid Proxy Part C Days CIRP
14-3380GC Capital Health System 2007 DSH/Medicare Part C Days - Medicaid Proxy CIRP
14-3381GC Capital Health System 2007 DSH/Medicare Part C Days – Medicare Proxy

Dear Mr. Glazer:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeals and, on July 17, 2019, as required by 42 C.F.R. § 405.1842(c), notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above referenced CIRP group cases. The Providers and the Medicare Contractor have also submitted comments as to whether the Board is without the authority to decide the following legal questions[1]:

> Whether the Intermediary wrongfully include the Provider's Medicare part C days in the Medicare Proxy used to calculate the Provider's allowable Medicare disproportionate share payment.[2]
>
> And,
> Whether the Intermediary failed to include all of the Provider's Medicare part C days in the numerator of the Medicaid Proxy used to calculate the Provider's allowable Medicare disproportionate Share hospital (DSH) payment.[3]

Both the Provider and the Medicare Contractor are in agreement that the Board does not have the authority to grant the relief sought.

[1] The Provider's comments were received on August 12th, 2019 and the Medicare contractor's comments were received on August 14th, 2019.
[2] Request for Hearing, Issue Statement, at Ex. 2 (Dec. 9, 2013), 14-1281G.
[3] Request for Hearing, Issue Statement, at Ex. 2 (Dec. 9, 2013), 14-1282G.

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[14]

Medicare Advantage Program

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

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

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

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

> including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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

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

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

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

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

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

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[16] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
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[19] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
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[21] 69 Fed. Reg. at 49099.

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

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

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

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

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

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

**Board's Consideration for Own Motion EJR**

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[31] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[32] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

**Decision of the Board**

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

*Jurisdiction for the Group Participants*

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006 through 2007.

[28] 863 F.3d 937 (D.C. Cir. 2017).
[29] *Id.* at 943.
[30] *Id.* at 943-945.
[31] 69 Fed. Reg. at 49099.
[32] *Allina* at 1109.

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

The Board has determined that the remaining participants' appeals involved with the instant EJR are governed by the decision in *Bethesda*. Each Provider appealed from an original NPR. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[35] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the referenced appeals and the participants.

*Board's Analysis Regarding the Appealed Issue*

The appeals in these EJR requests involve the fiscal years 2006 through 2007 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[36] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[37] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

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[33] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[34] *Bethesda*, 108 S. Ct. at 1258-59.
[35] *See* 42 C.F.R. § 405.1837.
[36] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[37] *See* 42 U.S.C. § 1395oo(f)(1).

*Board's Decision Regarding the Own Motion EJR*

The Board finds that:

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

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

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

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

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

**Board Members Participating:**

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

**For the Board:**

8/30/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Wilson Leong, Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

Joseph Glazer, Esq.
The Law Office of Joseph D. Glazer, P.C.
116 Village Blvd., Ste. 200
Princeton, NJ 08540

**RE:** ***Part C Days Medicaid and Medicare Proxy Groups – PRRB Own Motion Expedited Judicial Review Determination***

14-1286GC Cathedral 2006 DSH Medicare Proxy Medicare Managed Care Part C Days CIRP
14-1287GC Cathedral 2006 DSH Medicaid Proxy Medicare Managed Care Part C Days CIRP
14-3344GC Cathedral 2007 DSH Medicare Part C Days - Medicare Proxy CIRP Group
14-3346GC Cathedral 2007 DSH Medicare Part C Days - Medicaid Proxy CIRP Group

Dear Mr. Glazer:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeals and, on July 17, 2019, as required by 42 C.F.R. § 405.1842(c), notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above referenced CIRP group cases. The Providers and the Medicare Contractor have also submitted comments as to whether the Board is without the authority to decide the following legal questions[1]:

> Whether the Intermediary wrongfully include the Provider's Medicare part C days in the Medicare Proxy used to calculate the Provider's allowable Medicare disproportionate share payment.[2]
>
> And,
> Whether the Intermediary failed to include all of the Provider's Medicare part C days in the numerator of the Medicaid Proxy used to calculate the Provider's allowable Medicare disproportionate Share hospital (DSH) payment.[3]

Both the Provider and the Medicare Contractor are in agreement that the Board does not have the authority to grant the relief sought.

[1] The Provider's comments were received on August 12th, 2019 and the Medicare contractor's comments were received on August 14th, 2019.
[2] Request for Hearing, Issue Statement, at Ex. 2 (Dec. 11, 2013), 14-1286GC.
[3] Request for Hearing, Issue Statement, at Ex. 2 (Dec. 11, 2013), 14-1287GC.

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[14]

Medicare Advantage Program

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

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

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

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

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

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**Board's Consideration for Own Motion EJR**

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[31] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[32] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

**Decision of the Board**

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

*Jurisdiction for the Group Participants*

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006 through 2007.

[28] 863 F.3d 937 (D.C. Cir. 2017).
[29] *Id.* at 943.
[30] *Id.* at 943-945.
[31] 69 Fed. Reg. at 49099.
[32] *Allina* at 1109.

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

The Board has determined that the remaining participants' appeals involved with the instant EJR are governed by the decision in *Bethesda*. Each Provider appealed from an original NPR. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[35] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the referenced appeals and the participants.

*Board's Analysis Regarding the Appealed Issue*

The appeals in these EJR requests involve the fiscal years 2006 through 2007 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[36] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[37] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

[33] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[34] *Bethesda*, 108 S. Ct. at 1258-59.
[35] *See* 42 C.F.R. § 405.1837.
[36] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[37] *See* 42 U.S.C. § 1395oo(f)(1).

*Board's Decision Regarding the Own Motion EJR*

The Board finds that:

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

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

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

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

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

**Board Members Participating:**

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Charlotte F. Benson, CPA
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Robert A. Evarts, Esq.
Susan A. Turner, Esq.

**For the Board:**

8/30/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Wilson Leong, Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc.