DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Healthcare Reimbursement Services, Inc.
Corinna Goron
C/O Appeals Department
17101 Preston Rd., Ste. 220
Dallas, TX 75248-1372

CGS Administrators
Judith Cummings
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2013 Standardized Payment Amount CIRP Group
Case No. 19-2160GC

Dear Ms. Goron and Ms. Cummings,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned common issue related party ("CIRP") group appeal on its own motion. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Background

On July 1, 2019, the Providers filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted:

> The Provider(s) contend(s) that the MAC's determination for their standardized payment amount was calculated improperly and set too low based on erroneous methodology.
>
> Under the Inpatient Prospective Payment System, hospitals are paid a fixed amount for each Medicare beneficiary that they treat, "regardless of the actual operating costs they incur." *See Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 133 S. Ct. 817, 822, 184 L. Ed. 2d 627 (2013). This fixed amount is calculated by starting with ***a base rate*** that is then adjusted in various ways for each specific beneficiary at each specific hospital. See 42 U.S.C. § 1395ww(d)(2).
>
> The ***base rate*** used 1981 hospital cost reporting data, and was first developed in 1983 for use in the 1984 fiscal year. The ***base rate*** was partially determined by the average cost-per-discharge. 42 U.S.C. § 1395ww(d)(2). The base year 1981 data did not distinguish between patient discharges and patient transfers. Both were classified as discharges. Therefore, the 1981 data over-

> counted discharges, by including both discharges and transfers in the baseline data.
>
> The result of this error was to spread total operating costs over an artificially high number of discharges, thereby yielding a lower average cost-per-discharge. This in turn lead to a ***base rate*** that was lower than it would have been had the total number of patient discharges been accurately computed. As this error in the ***base rate*** has never been corrected, the standardized payment amount has been lower than it should have been in every year since 1984. Accordingly, for the reason stated above, provider hereby appeals the standardized payment amount for the years at issue in this cost report.[1]

There are five (5) participants in this group appeal. All participants appealed from Revised Notices of Program Reimbursement ("RNPRs").

A. Background on Participant #1 – Cleveland Clinic

On September 17, 2018, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Cleveland Clinic. This reopening notice states that the cost report was reopened solely for the following issue related to the calculation of the disproportionate share hospital ("DSH") adjustment:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request received 09/13/2018.[2]

Cleveland Clinic received its RNPR on January 9, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."

B. Background on Participant #2 – South Point Hospital

On September 17, 2018, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for South Pointe Hospital. This reopening notice states that the cost report was reopened solely for the following DSH issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request received 09/13/2018.[3]

South Point Hospital received its RNPR on January 30,2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."

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[1] *Model Form B – Group Appeal Request* (July 1, 2019) (emphasis added).
[2] *Model Form B – Group Appeal Request* (July 1, 2019).
[3] *Model Form B – Group Appeal Request* (July 1, 2019).

C. Background on Participant #3 – Lutheran Medical Center

On September 14, 2018, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Lutheran Medical Center. This reopening notice states that the cost report was reopened solely for the following DSH issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request received 09/13/2018. [4]

Lutheran Medical Center received its RNPR on February 12, 2020. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The SSI percentage is used in the calculation of the disproportionate share hospital ("DSH") adjustment.

D. Background on Participant #4 – Hillcrest Hospital

On September 17, 2018, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Hillcrest Hospital. This reopening notice states that the cost report was reopened solely for the following DSH issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request received 09/13/2018.[5]

Hillcrest Hospital received its RNPR on March 6, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."

E. Background on Participant #5 – Euclid Hospital

On September 14, 2018, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Euclid Hospital. This reopening notice states that the cost report was reopened solely for the following DSH issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request received 09/13/2018.[6]

Euclid Hospital received its RNPR on March 13, 2019. The RNPR included an adjustments "to update the SSI% and DSH payment factor in accordance with CMS SSI realignment calculation."

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[4] *Model Form B – Group Appeal Request* (July 1, 2019).
[5] *Model Form B – Group Appeal Request* (July 1, 2019).
[6] *Model Form B – Group Appeal Request* (July 1, 2019).

Board Decision

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

Relevant Regulations – Revised NPRs

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

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not ***specifically revised*** (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.[7]

The Board finds that it does not have jurisdiction over any of the five participants in this appeal because they ***each*** appealed from an RNPR that did *not* adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register).

[7] (Emphasis added.)

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are *specifically* revised."[8] The reopenings in this case were a result of the Providers' request to realign their SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end pursuant to the process permitted under 42 C.F.R. § 412.106(b)(3). The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[9] The Notices of Reopening explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determinations were only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPRs were adjustments related to realigned SSI percentages and the RNPRs did *not* adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register), the Board does not have jurisdiction over these participants in the subject group appeal. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[10]

In conclusion, the Board dismisses all five participants from the appeal as they do not have the right to appeal the RNPRs at issue under 42 C.F.R. § 405.1889. As there are no participants remaining, the Board hereby closes Case No. 19-2160GC and removes it from the Board's

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[8] 42 C.F.R. § 405.1889(b)(1) (emphasis added).

[9] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (describing the data match process CMS uses). Further, as noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis. As a result, the month-by-month data underlying the relevant published SSI percentages remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. For example, if a provider has a fiscal year ending ("FYE") December 31st and requested that the SSI percentage for its FYE 12/31/2012 be realigned from FFY 2012 (*i.e.*, October 1, 2011 through September 30, 2012) to the provider's FYE 12/31/2012 (*i.e.*, January 2012 through December 2012), CMS would use the month-by-month data for January 2012 through December 2012 that underlie the relevant published FFY SSI percentages which, in this example, would be the SSI percentages for FFY 2012 and FFY 2013 since the provider's fiscal year spans those FFYs (*i.e.*, the new SSI percentage realigned to the provider's FYE 12/31/2012 would be based on: a) the monthly data for January 2012 through September 2012 which was used in the published FFY 2012 SSI percentage; and b) the monthly data for October 2012 through December 2012 which was used in the published FFY 2013 SSI percentage). *See* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction *using SSI and Medicare data* ***derived from*** the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period. (emphasis added)); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

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

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

FOR THE BOARD:

8/5/2020

X Clayton J. Nix

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

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

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P.O. Box 20020
Nashville, TN 37202

RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2014 Standardized Payment Amount CIRP Group
Case No. 19-2288GC

Dear Ms. Goron and Ms. Cummings,

The Provider Reimbursement Review Board ("Board") has reviewed the above- captioned appeal on its own motion. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Background

On July 24, 2019, the Providers filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted:

> The Provider(s) contend(s) that the MAC's determination for their standardized payment amount was calculated improperly and set too low based on erroneous methodology.
>
> Under the Inpatient Prospective Payment System, hospitals are paid a fixed amount for each Medicare beneficiary that they treat, "regardless of the actual operating costs they incur." *See Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 133 S. Ct. 817, 822, 184 L. Ed. 2d 627 (2013). This fixed amount is calculated by starting with ***a base rate*** that is then adjusted in various ways for each specific beneficiary at each specific hospital. See 42 U.S.C. § 1395ww(d)(2).
>
> The ***base rate*** used 1981 hospital cost reporting data, and was first developed in 1983 for use in the 1984 fiscal year. The ***base rate*** was partially determined by the average cost-per-discharge. 42 U.S.C. § 1395ww(d)(2). The base year 1981 data did not distinguish between patient discharges and patient transfers. Both were classified as discharges. Therefore, the 1981 data over-

> counted discharges, by including both discharges and transfers in the baseline data.
>
> The result of this error was to spread total operating costs over an artificially high number of discharges, thereby yielding a lower average cost-per-discharge. This in turn lead to a ***base rate*** that was lower than it would have been had the total number of patient discharges been accurately computed. As this error in the ***base rate*** has never been corrected, the standardized payment amount has been lower than it should have been in every year since 1984. Accordingly, for the reason stated above, provider hereby appeals the standardized payment amount for the years at issue in this cost report.[1]

There are three (3) participants in this group appeal and both of these participants appealed from Revised Notices of Program Reimbursement ("RNPRs").

A. Background on Participant #1 – Lutheran Medical Center

On September 17, 2018, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Lutheran Medical Center. This reopening notice states that the cost report was reopened solely for the following issue related to the calculation of the disproportionate share hospital ("DSH") adjustment:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request received 09/13/2018[2]

Lutheran Medical Center received its RNPR on January 30, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."

B. Background on Participant #2 – Marymount Hospital

On September 17, 2018, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Marymount Hospital. This reopening notice states that the cost report was reopened solely for the following DSH issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request received 09/13/2018.[3]

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[1] *Model Form B – Group Appeal Request* (July 24, 2019) (emphasis added).
[2] *Model Form B – Group Appeal Request* (July 24, 2019).
[3] *Model Form B – Group Appeal Request* (July 24, 2019).

Marymount Hospital received its RNPR on January 30, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."

C. *Background on Participant #3 – Cleveland Clinic*

On September 17, 2018, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Cleveland Clinic. This reopening notice states that the cost report was reopened solely for the following DSH issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request received 09/13/2018.[4]

Cleveland Clinic received its RNPR on January 30, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."

Board Decision

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

Relevant Regulations – Revised NPRs

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

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

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

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

[4] *Model Form B – Group Appeal Request* (July 24, 2019).

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

The Board finds that it does not have jurisdiction over the three participants in this appeal because they each appealed from RNPRs that did not adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register).

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."[5] The reopenings in this case were a result of the Providers' request to realign their SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end pursuant to the process permitted under 42 C.F.R. § 412.106(b)(3). The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[6] The Notices of Reopening explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determinations were only being reopened to include realigned

[5] 42 C.F.R. § 405.1889(b)(1) (emphasis added).

[6] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (describing the data match process CMS uses). Further, as noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis. As a result, the month-by-month data underlying the relevant published SSI percentages remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. For example, if a provider has a fiscal year ending ("FYE") December 31st and requested that the SSI percentage for its FYE 12/31/2012 be realigned from FFY 2012 (*i.e.*, October 1, 2011 through September 30, 2012) to the provider's FYE 12/31/2012 (*i.e.*, January 2012 through December 2012), CMS would use the month-by-month data for January 2012 through December 2012 that underlie the relevant published FFY SSI percentages which, in this example, would be the SSI percentages for FFY 2012 and FFY 2013 since the provider's fiscal year spans those FFYs (*i.e.*, the new SSI percentage realigned to the provider's FYE 12/31/2012 would be based on: a) the monthly data for January 2012 through September 2012 which was used in the published FFY 2012 SSI percentage; and b) the monthly data for October 2012 through December 2012 which was used in the published FFY 2013 SSI percentage). *See* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction *using SSI and Medicare data* ***derived from*** the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period. (emphasis added)); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

SSI percentages. Since the only matters specifically revised in the RNPRs were adjustments related to realigned SSI percentages and the RNPRs did *not* adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register), the Board does not have jurisdiction over these participants in the subject group appeal. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[7]

In conclusion, all three participants are dismissed from the appeal as they do not have the right to appeal the RNPRs at issue under 42 C.F.R. § 405.1889. As there are no participants remaining, the Board hereby closes Case No. 19-2288GC 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
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

8/5/2020

X Clayton J. Nix

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

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

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

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RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2008 Standardized Payment Amount CIRP Group
Case No. 20-1547GC

Dear Ms. Goron and Ms. Cummings,

The Provider Reimbursement Review Board ("Board") has reviewed the above- captioned appeal on its own motion. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Background

On April 6, 2020, the Providers filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted:

> The Provider(s) contend(s) that the MAC's determination for their standardized payment amount was calculated improperly and set too low based on erroneous methodology.
>
> Under the Inpatient Prospective Payment System, hospitals are paid a fixed amount for each Medicare beneficiary that they treat, "regardless of the actual operating costs they incur." *See Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 133 S. Ct. 817, 822, 184 L. Ed. 2d 627 (2013). This fixed amount is calculated by starting with ***a base rate*** that is then adjusted in various ways for each specific beneficiary at each specific hospital. See 42 U.S.C. § 1395ww(d)(2).
>
> The ***base rate*** used 1981 hospital cost reporting data, and was first developed in 1983 for use in the 1984 fiscal year. The ***base rate*** was partially determined by the average cost-per-discharge. 42 U.S.C. § 1395ww(d)(2). The base year 1981 data did not distinguish between patient discharges and patient transfers. Both were classified as discharges. Therefore, the 1981 data over-counted discharges, by including both discharges and transfers in the baseline data.

> The result of this error was to spread total operating costs over an artificially high number of discharges, thereby yielding a lower average cost-per-discharge. This in turn lead to a ***base rate*** that was lower than it would have been had the total number of patient discharges been accurately computed. As this error in the ***base rate*** has never been corrected, the standardized payment amount has been lower than it should have been in every year since 1984. Accordingly, for the reason stated above, provider hereby appeals the standardized payment amount for the years at issue in this cost report.[1]

There is only one participant in this group appeal and it appealed from a Revised Notice of Program Reimbursement ("RNPR").

A. Background on Participant #1 – Fairview Hospital

On March 3, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Fairview Hospital. This reopening notice states that the cost report was reopened solely for the following issue related to the calculation of the disproportionate share hospital ("DSH") adjustment:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 03/02/2016.[2]

Fairview Hospital received its RNPR on October 2, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' realignment calculation."

Board Decision

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

Relevant Regulations – Revised NPRs

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

> (a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in

[1] *Model Form B – Group Appeal Request* (April 2, 2020) (emphasis added).
[2] *Model Form B – Group Appeal Request* (April 2 2020).

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

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

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

The Board finds that it does not have jurisdiction over the participant in this appeal because it appealed from a RNPR that did not adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are *specifically* revised."[3] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end pursuant to the process permitted under 42 C.F.R. § 412.106(b)(3). The audit adjustments associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[4] The Notice of Reopening explicitly stated that the purpose of

[3] 42 C.F.R. § 405.1889(b)(1) (emphasis added).

[4] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (describing the data match process CMS uses). Further, as noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis. As a result, the month-by-month data underlying the relevant published SSI percentages remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. For example, if a provider has a fiscal year ending ("FYE") December 31st and requested that the SSI percentage for its FYE 12/31/2012 be realigned from FFY 2012 (*i.e.*, October 1, 2011 through September 30, 2012) to the provider's FYE 12/31/2012 (*i.e.*, January 2012 through December 2012), CMS would use the month-by-month data for January 2012 through December 2012 that underlie the relevant published FFY SSI percentages which, in this example, would be the SSI percentages for FFY 2012 and FFY 2013 since the provider's fiscal year spans those FFYs (*i.e.*, the new SSI percentage realigned to the provider's FYE 12/31/2012 would be based on: a) the monthly data for January 2012 through September 2012 which was used

the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPR were adjustments related to realigned SSI percentages and the RNPRs did *not* adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register), the Board does not have jurisdiction over the participant in the subject group appeal. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[5]

In conclusion, the Board dismisses Fairview Hospital from the appeal as it does not have the right to appeal the RNPR at issue under 42 C.F.R. § 405.1889. As there are no participants remaining, the Board hereby closes Case No. 20-1547GC 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.
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FOR THE BOARD:

8/5/2020

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

in the published FFY 2012 SSI percentage; and b) the monthly data for October 2012 through December 2012 which was used in the published FFY 2013 SSI percentage). *See* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction *using SSI and Medicare data* ***derived from*** the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period. (emphasis added)); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Decision***
Cleveland Clinic Fdn. CY 2011 Standardized Payment Amount CIRP Group
Case No. 20-1580GC

Dear Ms. Goron and Ms. Cummings,

The Provider Reimbursement Review Board ("Board") has reviewed the above- captioned appeal on its own motion. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Background

On April 15, 2020, the Providers filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted:

> The Provider(s) contend(s) that the MAC's determination for their standardized payment amount was calculated improperly and set too low based on erroneous methodology.
>
> Under the Inpatient Prospective Payment System, hospitals are paid a fixed amount for each Medicare beneficiary that they treat, "regardless of the actual operating costs they incur." *See Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 133 S. Ct. 817, 822, 184 L. Ed. 2d 627 (2013). This fixed amount is calculated by starting with ***a base rate*** that is then adjusted in various ways for each specific beneficiary at each specific hospital. See 42 U.S.C. § 1395ww(d)(2).
>
> The ***base rate*** used 1981 hospital cost reporting data, and was first developed in 1983 for use in the 1984 fiscal year. The ***base rate*** was partially determined by the average cost-per-discharge. 42 U.S.C. § 1395ww(d)(2). The base year 1981 data did not distinguish between patient discharges and patient transfers. Both were classified as discharges. Therefore, the 1981 data over-

> counted discharges, by including both discharges and transfers in the baseline data.
>
> The result of this error was to spread total operating costs over an artificially high number of discharges, thereby yielding a lower average cost-per-discharge. This in turn lead to a ***base rate*** that was lower than it would have been had the total number of patient discharges been accurately computed. As this error in the ***base rate*** has never been corrected, the standardized payment amount has been lower than it should have been in every year since 1984. Accordingly, for the reason stated above, provider hereby appeals the standardized payment amount for the years at issue in this cost report.[1]

There are three participants in this group appeal and both of these participants appealed from Revised Notices of Program Reimbursement ("RNPRs").

A. Background on Participant #1 – Fairview Hospital

On November 14, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Fairview Hospital. This reopening notice states that the cost report was reopened solely for the following issue related to the calculation of the disproportionate share hospital ("DSH") adjustment:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 11/10/2016.[2]

Fairview Hospital received its RNPR on December 4, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."

B. Background on Participant #2 – Euclid Hospital[3]

On November 14, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Euclid Hospital. This reopening notice states that the cost report was reopened solely for the following DSH issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 11/10/2016.

Euclid Hospital received its RNPR on December 12, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."

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[1] *Model Form B – Group Appeal Request* (April 15, 2020) (emphasis added).
[2] *Model Form B – Group Appeal Request* (April 15, 2020).
[3] Directly added April 28, 2020

C. Background on Participant #3 – Lakewood Hospital[4]

On November 14, 2016, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for Lakewood Hospital. This reopening notice states that the cost report was reopened solely for the following DSH issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 11/09/2016.

Lakewood Hospital received its RNPR on February 12, 2020. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."

Board Decision

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

Relevant Regulations – Revised NPRs

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

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

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

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

[4] Directly added May 28, 2020

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

The Board finds that it does not have jurisdiction over the three participants in this appeal because they each appealed from RNPRs that did not adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register).

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."[5] The reopenings in this case were a result of the Providers' request to realign their SSI percentage from the Federal Fiscal Year End to its individual cost reporting fiscal year end pursuant to the process permitted under 42 C.F.R. § 412.106(b)(3). The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[6] The Notices of Reopening explicitly stated that the purpose of the reopening was "to update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the provider's request ..." In other words, the determinations were only being reopened to include realigned

[5] 42 C.F.R. § 405.1889(b)(1) (emphasis added).

[6] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (describing the data match process CMS uses). Further, as noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis. As a result, the month-by-month data underlying the relevant published SSI percentages remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. For example, if a provider has a fiscal year ending ("FYE") December 31st and requested that the SSI percentage for its FYE 12/31/2012 be realigned from FFY 2012 (*i.e.*, October 1, 2011 through September 30, 2012) to the provider's FYE 12/31/2012 (*i.e.*, January 2012 through December 2012), CMS would use the month-by-month data for January 2012 through December 2012 that underlie the relevant published FFY SSI percentages which, in this example, would be the SSI percentages for FFY 2012 and FFY 2013 since the provider's fiscal year spans those FFYs (*i.e.*, the new SSI percentage realigned to the provider's FYE 12/31/2012 would be based on: a) the monthly data for January 2012 through September 2012 which was used in the published FFY 2012 SSI percentage; and b) the monthly data for October 2012 through December 2012 which was used in the published FFY 2013 SSI percentage). *See* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction *using SSI and Medicare data* ***derived from*** the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period. (emphasis added)); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

SSI percentages. Since the only matters specifically revised in the RNPRs were adjustments related to realigned SSI percentages and the RNPRs did *not* adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register), the Board does not have jurisdiction over these participants in the subject group appeal. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[7]

In conclusion, the Board dismisses all three participants from the appeal as they do not have the right to appeal the RNPRs at issue under 42 C.F.R. § 405.1889. As there are no participants remaining, the Board hereby closes Case No. 20-1580GC 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
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

8/5/2020

X Clayton J. Nix

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Chair
Signed by: Clayton J. Nix -A

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Request for Reconsideration of Bifurcation and Jurisdictional Determination***
UC 2002 DSH Dual Eligible Days CIRP Group
Case No. 09-0497GC

Dear Mr. Knight and Ms. Frewert:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above-referenced common issue related party ("CIRP") group appeal for the University of California Health System ("UCHS") in response to the request that the Board reconsider its December 30, 2015 decision in the UC 2002 DSH Dual Eligible Days Group. For the reasons explained below, the Board *denies* the request for reconsideration and Case No. 09-0497GC remains closed.

Background

On December 22, 2008, the Board received the Providers' initial request for the establishment of a group appeal for the UC Health System 2002 DSH Dual Eligible Days CIRP Group. This UCHS CIRP group for the identified the following issue:

> Whether the Medicaid Ratio used to calculate Medicare Disproportionate Share Payments (DSH) accurately reflects the number of patient days furnished to patients eligible for Medicaid in situations where the patient is also enrolled in the Medicare Part A Program but is not entitled to Medicare Part A benefits?
>
> We contend that the number of Medicaid eligible patient days used in the DSH calculation are understated due to exclusion of various categories of Medicaid eligible patients who enrolled in Medicare Part A but are not entitled to Medicare Part A benefits. Specifically, the Intermediary has incorrectly implemented a review process that excludes patient days applicable to patients that are eligible for Medicare Part A benefits without Medicare Part A entitlement in determining the number Medicaid eligible

> patients to be included in the Medicaid patient ratio of Medicare DSH calculation.[1]

On December 26, 2012, Toyon requested bifurcation of 09-0497GC to establish a separate CIRP group for the Part C days issue. On December, 30, 2015, the Board issued a December 30, 2015 decision denying bifurcation of the dual eligible Part A and Part C days issues, finding that the ***group issue*** statement did not identify dual eligible Part C days with the requisite specificity, as required by the regulations, to allow the Board to assume jurisdiction over this issue. In this decision this Board also denied jurisdiction over UC Irvine (Prov. No. 05-0348), because the Provider did not include the dual eligible days issue in its appeal request and did not timely request to add the issue to its appeal. Concurrently, on December 30, 2015, the Board issued a standard remand pursuant to CMS Ruling 1498-R for the dual eligible days and closed the instant CIRP group appeal.

On February 24, 2016, the Providers' representative, Toyon Associates, Inc. ("Toyon") requested that the Board reconsider its bifurcation denial relative to the following two (2) providers that remained in the UCHS CIRP group when the Board remanded the CIRP group pursuant to CMS Ruling 1498-R:

1. UC Davis Medical Center, Prov. No. 05-0454 ("UC Davis"); and
2. UC San Francisco Medical Center, Prov. No. 05-0454 ("UCSF").

Providers' Request for Reconsideration:

Toyon offers several arguments in support of its position that the Board should reverse its decision as related to the Dual Eligible Part C days issue for UC Davis and UCSF. Toyon first argues that the Providers' intent to appeal "the whole dual eligible days issue" was expressed in the language the Providers used in their appeal and transfer requests. Toyon also argues that the factual and historical context of the appeal requests support the conclusion that the Providers intended to appeal both issues. At the time this group appeal request was filed, providers commonly appealed the dual eligible days issue generally, contesting the categorical exclusion of all dual eligible days based on patients' status as Medicare beneficiaries.

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2008), a group of providers have a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if: (1) they are dissatisfied with their respective final determination of the Medicare contractor; (2) the amount in controversy is $50,000 or more; and (3) the providers' requests for hearing are filed within 180 days of the date of receipt of their respective final determinations. Pursuant to 42 C.F.R. § 405.1837(a)(2) (2008), the matter at issue in a group appeal must involve a single common question of fact or interpretation of law, regulation or CMS policy or ruling.

[1] Group appeal request received on December 22, 2008.

A. Jurisdiction Decision – UC Irvine (Prov. No. 05-0348)

At the outset, the Board notes that it issued a previous decision to deny jurisdiction over UC Irvine because the Provider did not timely appeal or add the dual eligible days issue to its individual appeal. This determination does not reconsider this denial since the Request for Reconsideration is explicitly limited to UC Davis and UCSF (and because there was no additional evidence submitted for the Board to reconsider is dismissal of UC Irvine).

B. Denial of Request for Reconsideration

In the instant case, the Board received the CIRP group appeal request for Case No. 09-0497GC on December 22, 2008. The request for reconsideration only involves the two participants that remained in this case at the time of the Board's remand–UC Davis and UCSF.

Earlier, by a letter dated January 19, 2005, UC Davis had established its individual appeal and this appeal included the Dual Eligible Days issue as Issue 2 but did not separately list out Part C Days. UC Davis later transferred the Dual Eligible Days issue to Case No. 09-0497GC.

By a letter dated July 8, 2010, UCSF established an individual appeal and, unlike UC Davis, UCSF had both a Dual Eligible Part A Days issue (Issue 2) ***and*** a Dual Eligible Part C Days issue (Issue 3). Significantly, UCSF's representative in the individual case is the same as that for the group case -- Toyon Associates, Inc. By letter dated September 15, 2010, UCSF requested to transfer "Issue 2 – Medicare DSH Payments-Dual Eligible Part A Days" into the CIRP group. The Board records reflect that, on September 23, 2010, UCSF requested that Issue 3, the Dual Eligible Part C issue, be transferred to the CIRP group under Case No. 10-1370GC.

The Board previously found that the group appeal issue statement does *not* specifically identify DSH dual eligible Part C[2] days as being part of the dual eligible days issue.[3] The Board affirms its previous decision because additional information demonstrates that the Board was correct in its finding and, as such, Case No. 09-0497GC remains closed. Upon further review of its docket, the Board has discovered that, *more than two years prior to the original December 26, 2012 request for bifurcation and more than five years prior to the February 24, 2016 request for reconsideration*, Toyon had *already* established a CIRP group (Case No. 10-1370GC) on September 23, 2010 on behalf of the UCHS chain for the same year and the same issue. Indeed, it is clear that one participant in 09-0497GC, UCSF, had already *separately* appealed the Part C days issue (and transferred it into Case No. 10-1370GC) and, as such, it clear that Toyon's request to bifurcate the Dual Eligible Days issue for UCSF is invalid and has no foundation.

---

[2] The Medicare Part C program did not being 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.

[3] December 30, 2015 Board Determination.

Finally, on February 1, 2017, the Board notes that Toyon withdrew Case No. 10-1370GC (presumably due to an administrative resolution) and, on the same day, the Board has closed the case.

The Board further reminds the Group Representative *that he has a responsibility to track and manage his case load before the Board and ensure he exercises due diligence* ***prior to*** *making filings. In this regard, the Board notes that* ***the Group Representative failed to alert the Board*** *in either its request for bifurcation or its request for reconsideration that the UCHS* ***already*** *had pending before the Board a CIRP group for the same common issue and year (i.e., Case No. 10-1370GC) and explain how these requests in Case No. 09-0497GC remained relevant notwithstanding this other then-pending CIRP group and, in particular, could have any relevance to UCSF which had* ***already*** *specifically appealed the Part C Days issue as a separate and distinct issue and transferred that separate and distinct issue to Case No. 10-1370GC.* To the extent bifurcation request and reconsideration request had ***any*** relevancy, it appears to have been extinguished when the Group Representative withdrew and the Board closed Case No. 10-1370GC on February 1, 2017.

Board Members:

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For the Board:

8/12/2020

X Clayton J. Nix

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RE: ***Board Determination on Medicare Contractor Challenge***

Subject Individual Appeals:

16-2499 West Virginia University Hospital (Prov. No. 51-0001) FYE 12/31/2013
16-2474 United Hospital Center (Prov. No. 51-0006) FYE 12/31/2013

Subject Group Appeals:

17-0568GC QRS WVUHS 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group
17-0570GC QRS WVUHS 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
17-0571GC QRS WVUHS Pre-10/1/2013 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Group
19-2368GC WVU Medicine CY 2013 and later DSH SSI Fraction Medicare Managed Care Part C Days CIRP Group
19-2376GC WVU Medicine CY 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group

Dear Mr. Blumberg and Ms. Polson:

The Board has reviewed the subject cases in response to the Medicare Contractor's February 21, 2020 correspondence in which it challenges issue transfers from the above-captioned individual appeals to various common issue related party ("CIRP") group appeals. The pertinent facts and the Board's determinations are set forth below.

Pertinent Facts:

A. Case No. 16-2499 - West Virginia University Hospital:

The individual appeal was filed on September 19, 2016 from an original Notice of Program Reimbursement (NPR) dated March 24, 2016. The appeal included 2 issues: SSI Provider Specific and SSI Percentage.

The SSI Percentage issue included the following language:

> Whether the Medicare/SSI Fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)?
>
> The Provider also 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 Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refused to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[1]

B. ***Case No. 16-2474 - United Hospital Center:***

The individual appeal was filed on September 12, 2016 from an original NPR dated March 15, 2016. The appeal included the same 2 issues as in Case No. 16-2499: SSI Provider Specific and SSI Percentage. The SSI Percentage issue used same issue description.

C. Facts Occurring in Both Individual Appeals Under Case Nos. 16-2499 and 16-2474:

On May 26, 2017 (received by the Board on May 30, 2017), the SSI Percentage, SSI fraction Dual Eligible Days and SSI fraction Medicare Managed Care Part C Days issues were transferred to group Case Nos. 17-0567GC, 17-0570GCC and 17-0571GC, respectively.

On April 27, 2018 (received by the Board on April 30, 2018) the Medicare Contractor challenged jurisdiction over the SSI Provider Specific issue and over the untimely addition/improper bifurcation of the SSI fraction Dual Eligible Days and SSI fraction Medicare Managed Care Part C Days issues.

[1] Provider's appeal request, Issue 2 (Sept. 15, 2016)

On June 15, 2018, the Board denied jurisdiction over the SSI Provider Specific issue (which was the only issue in the both cases after the transfer of the SSI fraction Dual Eligible Days and SSI fraction Medicare Managed Care Part C Days issues) and both Case Nos. 16-2499 and 16-2474 were closed.

D. Case No. 19-2376GC- WVU Medicine CY 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group

On September 17, 2019, the Medicare Contractor submitted correspondence after its 30-day review of the group pursuant to Board Rule 15.2, in which it identified various jurisdictional impediments over West Virginia University Hospital and United Hospital Center as participants based on problems in the individual appeals from which the group ultimately stems.

On October 23, 2019, the Group Representative submitted a responsive brief in the group. The Representative argues that the Board has jurisdiction over all Providers in the group because the "Provider" (does not specify which Provider in the group) did have an adjustment to ". . . DSH and Medicaid Days. . . and such adjustment was enough to warrant Board jurisdiction over this appeal issue. However, Provider contends that the adjustment is not required, as DSH is not an item that has to be adjusted or claimed on a cost report."[2]

E. Medicare Contractor Jurisdictional Challenge Over Transfers/Bifurcations

On February 21, 2020 the Medicare Contractor filed a jurisdictional challenge in the following WVU Health System Cases: 16-2499, 16-2474, 17-0568GC, 17-0570GC, 17-0571GC, 17-2368GC and 17-2376GC. The Medicare Contractor requested that the Board deny jurisdiction over the SSI fraction Dual Eligible Days and SSI fraction Medicare Managed Care Part C Days issues as untimely added and then subsequently bifurcated in both individual appeals. The Medicare Contractor similarly requested that the Board *deny* the subsequent transfers to Case Nos. 17-0570GC and 17-0571GC, as well as the subsequent inclusion in the bifurcated groups Case Nos. 19-2376GC and 19-2368GC.

The Group Representative did not respond to the Medicare Contactor's Challenge.

Board Determination:

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

[2] Representative's Jurisdictional Review Response in Case No. 19-2376GC at pg.1. (Oct. 23, 2019)

A. Board Determination Regarding SSI Fraction Part C and Dual Eligible Days issues

The Board Rules in effect when the individual appeals for Case Nos. 16-2499 and 16-2474 were filed were issued on July 1, 2015 and addressed at Rule 8 the requirements for appealing issues involving multiple components:

> **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.)

In the subject individual appeals, the Board finds that both the SSI Fraction Dual Eligible and SSI fraction Medicare Managed Care Part C Days issues were addressed in the issue SSI Percentage issue statement in both individual appeals. Consequently, the Board finds that the transfer of the SSI Fraction Dual Eligible Days issue to Case No. 17-0570GC and the transfer of the SSI fraction Medicare Managed Care Part C Days issue to Case No. 17-0571GC were valid. Relatedly, the Board finds that West Virginia University Hospital and United Hospital Center were accurately bifurcated into the WVU Medicine 2013 & later DSH SSI Fraction Part C Days CIRP Group, Case No. 19-2368GC.

B. Board Determination To Reopen Case No. 17-0568GC To Void Transfers of Medicaid Fraction Issues and Rescind EJR Determination

The Providers' April 22, 2019 requests to transfer the Medicaid Fraction Managed Care Part C Days issues from Case Nos. 16-2499 and 16-2474 to the CIRP Group, Case No. 17-0568GC,[3] were not filed *until April 22, 2019*. However, the Board had *already* closed both cases more than 8 months earlier *on June 15, 201**8*** because, in each case, the Board dismissed the last remaining issue and closed the case. In this regard, the Board notes that only the SSI fraction was appealed and discussed; the Medicaid Fraction Managed Care Part C Days issue was not

[3] The Board notes that the Group Representative established this CIRP group with a group appeal request filed on November 28, 2016 and with one participant, Berkley Medical Center.

specifically mentioned in the SSI Percentage issue statements in the individual appeals for West Virginia University Hospital and United Hospital Center.

The Board recognizes that, on August 14, 2019, it granted expedited judicial review of the QRS WVUHS 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group (Pre-10/1/2013), Case No. 17-0568GC, and closed the case. Now that it has come to light that the transfers for two of the group participants were from otherwise closed cases and, as such, were ***automatically*** *invalid and void*, the Board hereby reopens Case No. 17-0568GC and dismisses West Virginia University Hospital and United Hospital Center from it. Further, pursuant to 42 C.F.R. § 405.1885, the Board reopens and rescinds the EJR determination for Case No. 17-0568GC in order to effectuate the void/invalid transfers and dismissals.[4]

In this regard, now that West Virginia University Hospital and United Hospital Center have been dismissed from the group, the sole the remaining provider in the group is Berkeley Medical Center dba City Hospital (Prov. No. 51-0008). Therefore, although Case No. 17-0568GC was established as a group appeal, *it now only has a single participant and, notwithstanding,* ***the Board is electing to maintain the case and treat it as an individual appeal*** *to minimize confusion since this is a revised EJR determination*. Concurrently, under separate cover, the Board is issuing the revised EJR determination for Case No. 17-0568GC for the sole remaining participant, Berkeley Medical Center.

C. Impact of Invalid/Voided Transfers on Case No. 19-2376GC

When the Board granted EJR over Case No. 17-0568GC, it also bifurcated from that case the period from October 1, 2013 and later for the Medicaid Fraction Managed Care Part C Days issue and assigned it to Case No. 19-2376GC. Therefore, as West Virginia University Hospital and United Hospital Center were ***never*** part of Case No. 17-0568GC, they were not eligible for bifurcation and, as a result, the Board hereby dismisses them from Case No. 19-2376GC that was created as a result of the bifurcation. As in Case No. 17-0568GC, there is only one participant remaining in the bifurcated CIRP group, Case No. 19-2376GC: Berkeley Medical Center dba City Hospital (Prov. No. 51-0008). Moreover, the Board *designated this CIRP group, 19-2376GC as fully formed* because it was bifurcated from Case No. 17-0568GC and the Group Representative had certified that Case No. 17-0568GC was fully formed (*i.e.*, that there were no other chain providers for the year at issue who would join the CIRP group whether by transfer of the common issue from an existing appeal or by a future appeal of the common issue). Since this issue is not currently subject to an expedited judicial review determination and since the Representative has already certified that the group is fully formed, the Board has elected to reinstate the individual appeal for sole remaining Provider individual appeal, Case No. 16-1331, in order to transfer the Medicaid Fraction Part C Days issue for the post October 1, 2013 period.

[4] The Board notes that the transfer of the Medicaid Fraction Medicare Managed Care Part C Days issue for West Virginia University Hospital, from Case No. 16-2499 to Case No. 17-0568GC, was previously denied by the Board on February 13, 2020.

The Parties will receive a Critical Due Dates notification for the reinstated case under separate cover.

D. Board Admonishment of the Group Representative in Case No. 17-0568GC and the Representative in Case Nos. 16-2499 and 16 2474

Finally, the Board has copied the designated Representative in Case Nos. 16-2499 and 16-2474 and ***the Board admonishes the Group Representative and the Representative in these Individual Cases*** for submitting transfer requests from these individual appeals to Case No. 17-0568GC that they should have known were ***both*** *invalid* ***and*** *void* since the individual cases had been closed for *over ten months* when the transfer requests were made. Accordingly, ***the Board reminds the Representatives that they have the responsibility to track and manage their cases and ensure they exercise due diligence prior to making filings***.

Moreover, it is clear that the Group Representative later missed an opportunity to redress the improper transfers. Specifically, the Group Representative failed to respond to the Medicare Contractor's Challenge filed on February 20, 2020 and, as a result, missed an opportunity to redress with the Board the otherwise invalid/void transfers as it relates ***both*** *to Case No. 17-0568GC* ***and*** *to Case No. 19-2376GC (as discussed above).*

The Board may consider taking remedial action if a trend in these types of erroneous and negligent filings develops.

Board Members Participating:
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For the Board:

8/12/2020

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services, Inc.
Amy Stephens, West Virginia University Health System

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RE: ***REISSUED EJR Determination***
QRS WVUHS 2013 DSH Medicaid Fraction Medicare Part C Days Group
Case No. 17-0568GC

Dear Mr. Ravindran and Ms. Polson:

The Provider Reimbursement Review Board ("Board") previously granted expedited judicial review ("EJR") for the above-referenced common issue related party ("CIRP") group appeal on August 14, 2019. However, as explained in a determination issued concurrent with this reissued EJR determination, the Board determined that there were automatic and fatal[1] jurisdictional impediments with regard to two of the participants in the group, which resulted in the reopening of Case No. 17-0568GC to dismiss those two participants and to reopen and rescind the prior August 14, 2019 EJR determination. Specifically, under separate cover, the Board reopened this CIRP group and dismissed West Virginia University Hospital (51-0001, FYE 12/31/2013) and United Hospital Center (51-0006, FYE 12/31/2013) from Case No. 17-0568GC and, as a result, reopened and rescinded the August 14, 2019 EJR determination. As set forth below, the Board is revising and reissuing the EJR determination to reflect for the sole remaining Provider, Berkeley Medical Center dba City Hospital (Prov. No. 51-0008).

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

[1] As explained in the reopening and dismissal, the *alleged* transfers of these two providers from their respective individual appeals (Case No. 16-2499 for West Virginia University Hospital and Case No. 16-2474 for United Hospital Center) to Case No. 17-0568GC were *automatically* invalid and void in the first instance because the transfers were submitted more than 10 months after the Board had closed these individual appeals (*i.e.*, more than 10 months after the Board had closed Case Nos. 16-2499 and 16-2474). *In this regard, the Board also admonished the Group Representative for submitting transfer requests from these individual appeals that it should have known were both invalid and void.*

> ("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]

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

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

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

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

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[2] Provider's EJR request at 1.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] (Emphasis added.)

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

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

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

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

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].

[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.

> 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 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

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

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]

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]

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[20] 69 Fed. Reg. at 49099.
[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).

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.

Provider's Request for EJR

In its original EJR request of June 19, 2019, the Provider previously explained 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 Provider contended that the Board should grant its request for EJR.

The Provider asserted 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 maintained 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 believed it had 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.

[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.
[30] Providers' EJR Request at 1.

A. Jurisdiction

The sole remaining group participant, Berkeley Medical Center d/b/a City Hospital (Prov. No. 51-0008) filed an appeal involving fiscal year 12/31/2013. The Medicaid Fraction Managed Care Part C days issue for the period from 1/1/2013 through 9/30/2013 was transferred to Case No. 17-0568GC.[31]

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

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

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

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[31] The remaining portion of the FYE from 10/1/2013 to 12/31/2013 was bifurcated and placed into Case No. 19-2376GC.
[32] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[33] *Bethesda*, 108 S. Ct. at 1258-59.
[34] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[35] 201 F. Supp. 3d 131 (D.D.C. 2016).
[36] *Id.* at 142.

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.

Although Case No. 17-0568GC was initially established as a group appeal, ***it now has only a single participant and the Board is electing to treat the case as an individual appeal***. The Board has determined that the appeal of Berkeley Medical Center d/b/a City Hospital (Prov. No. 51-0008) is governed by CMS Ruling 1727-R as the Provider is challenging a regulation. In addition, the participant's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal.[37] The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

B. Board's Analysis Regarding the Appealed Issue

The appeal in this EJR request involves the 1/1/2013 through 9/30/2013 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 this request, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[38] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Provider would have the right to bring suit in either the D.C. Circuit *or* the circuit within which it is located.[39] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

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[37] *See* 42 C.F.R. § 405.1835(a)(2).
[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).

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

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:

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FOR THE BOARD:

8/12/2020

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

cc: Laurie Polson, Palmetto GBA c/o NGS (Electronic Mail)
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RE: ***Jurisdictional Decision***
Grant Medical Center (36-0017)
Case No. 20-1299

Dear Mr. Johnston and Ms. Cummings,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above-captioned appeal on its own motion. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Pertinent Facts

The Provider filed a timely appeal with the Board on March 2, 2020 from a Revise Notice of Program Reimbursement ("revised NPR") dated September 4, 2019. The appeal has one issue, "The Improper treatment of Part C Days in the DSH calculation".

The revised NPR at issue arose because the Provider requested a recalculation of the Medicare SSI percentage based upon the provider's cost report period in accordance with the regulation 42 C.F.R. § 405.106(b)(3).[1] The regulation, 42 C.F.R. § 412.106(b)(3), permits a provider to request to have its data reported on its cost reporting period instead of the Federal fiscal year. To do so, "It must furnish to CMS, through its Intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period."

The Provider requested that its SSI percentages be recalculated from the federal fiscal year to its cost reporting year. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage.[2] Further, all of the underlying data (which is gathered on a month-by-month basis) remains the same and the realigned SSI percentage simply reflects a different time

[1] Recalculation request dated September 13, 2011.
[2] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). Similarly, CMS' policy on Part C days was set in the FFY 2005 Final Rule and is incorporated into and reflected in this data matching process. *See* 75 Fed. Reg. at 50276, 50285-6.

period being used.[3] 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 percentages) and reports it on the provider's cost reporting period instead of the September 30 Federal Fiscal Year.

Through the Provider's Notice of Reopening, the Medicare Contractor agreed to reopen the cost report once a response was received from CMS to update the SSI ratio.[4] The Provider received a RNPR "[t]o update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." The disputed RNPR only adjusted the SSI% to the realigned ratio (from the Federal Fiscal Year to the Provider's cost report year). The issue for the subject appeal states:

> Did the MAC err by not properly including Medicare Part C days when calculating the Provider's DSH percentage?
>
> The Provider believes the MAC failed to properly include appropriate bed days associated with certain Medicare Part C patients in the calculation of the Provider's DSH percentages, including the impact on the Medicare and Medicaid fractions.
>
> Provider believe that the applicable Medicare DSH regulation defines the numerator of the Medicare fraction as the number of days the hospital spent caring for Part A-entitled patients who were also entitled to income support payments under the Social Security Act. *See*, respectively, 42 C.F.R. § 412.106(b)(4) and 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The group members believe that the MAC's treatment of bed days, specifically for those patients who are receiving benefits from the Medicare Part C (Medicare Advantage) program, in the Medicare and Medicaid fractions of the DSH calculation is in violation of the plain language of the applicable regulations, including but not limited to, 42 C.F.R.§ 412.106(b)(4) and the Supreme Court's recent holding in Azar v. Allina Health Services, 139 S. Ct. 1804 (2019).[5]

Board Decision

The Board finds that it does not have jurisdiction over the Part C days issue from the revised NPR, as the specific issue, as described, was not adjusted as part of the revised NPR.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2018) provides in relevant part:

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[3] As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis.
[4] Notice of Intent to Reopen Cost Report dated October 12, 2015.
[5] Provider's issue statement (Model Form A)

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:[6]

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

These regulations make clear that a provider can only appeal items that are specifically revised from a revised NPR.

The Provider appealed the following issue from the revised NPR:

> The Provider believes the MAC failed to properly include appropriate bed days associated with certain Medicare Part C patients in the calculation of the Provider's DSH percentages, including the impact on the Medicare and Medicaid fractions.

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

> Provider believe that the applicable Medicare DSH regulation defines the numerator of the Medicare fraction as the number of days the hospital spent caring for Part A-entitled patients who were also entitled to income support payments under the Social Security Act. *See*, respectively, 42 C.F.R. § 412.106(b)(4) and 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The group members believe that the MAC's treatment of bed days, specifically for those patients who are receiving benefits from the Medicare Part C (Medicare Advantage) program, in the Medicare and Medicaid fractions of the DSH calculation is in violation of the plain language of the applicable regulations, including but not limited to, 42 C.F.R.§ 412.106(b)(4) and the Supreme Court's recent holding in Azar v. Allina Health Services, 139 S. Ct. 1804 (2019).[7]

The adjustment included in the revised NPR and that is the subject of this appeal, clearly show it was as a result of SSI realignment that changed the 12-month time period from the FFY ending September 30 to the Provider's cost reporting period. The Provider in this appeal is not challenging that the Medicare Contractor or CMS did not calculate the realigned SSI ratio correctly for those dates, but instead challenges an aspect of the agency's methodology for counting the days that are reflected in each months data, specifically they challenge the inclusion of Part C days in the SSI percentage and asserts instead that they should be counted in the Medicaid fraction. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage[8] and, in addition, all of the underlying data (which is gathered on a month-by-month basis) remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used.[9] More specifically, the realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI

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[7] Provider's issue statement (Model Form A)

[8] *See supra* note 2.

[9] *See supra* note 3. For example, if a provider has a fiscal year ending ("FYE") December 31st and requested that the SSI percentage for its FYE 12/31/2012 be realigned from FFY 2012 (*i.e.*, October 1, 2011 through September 30, 2012) to the provider's FYE 12/31/2012 (*i.e.*, January 2012 through December 2012), CMS would use the month-by-month data for January 2012 through December 2012 that underlie the relevant published FFY SSI percentages which, in this example, would be the SSI percentages for FFY 2012 and FFY 2013 since the provider's fiscal year spans those FFYs (*i.e.*, the new SSI percentage realigned to the provider's FYE 12/31/2012 would be based on: a) the monthly data for January 2012 through September 2012 which was used in the published FFY 2012 SSI percentage; and b) the monthly data for October 2012 through December 2012 which was used in the published FFY 2013 SSI percentage). *See* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY.

In conclusion, the Board hereby dismisses the DSH Part C Days issue from this appeal as 42 C.F.R. § 405.1889(b) does not allow the Provider to appeal it from the RNPR at issue. As there are no remaining issues in this appeal, the Board dismisses Case No. 20-1299 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:

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FOR THE BOARD:

8/13/2020

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RE: ***EJR Determination***
HLB FFY 2020 Rural Floor Exclusion of Reclassified Hospitals' Wage Data Group
Case No. 20-0848G

Dear Mr. Vernon:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 2, 2020 request for expedited judicial review ("EJR") for the above-referenced group appeal. On July 29, 2020, the Board sent the Group Representative asking if the regulations regarding group appeals commonly owned or controlled providers (CIRP groups) found at 42 C.F.R. § 405.1837(b)(1)(iii) and 405.1835(b)(4) were applicable to four of the participants in this case. The Group Representative responded on August 4, 2020, to confirm that these CIRP group requirements were not applicable to any of the Providers and, as a result, CIRP groups were not required for any of the Providers. The decision of the Board is set forth below.

The issue for which EJR has been requested involves:

> Whether the Hospitals' FFY [Federal fiscal year] 2020 area wage index ("AWI") values and commensurate IPPS [Inpatient Prospective Payment System] payments were improperly reduced for FFY 2020 because the Secretary[1] excluded the wage data of urban hospitals that have been reclassified to rural status from the rural floor calculation.[2]

Statutory and Regulatory Background

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

[1] of the Department of Health and Human Services.
[2] Providers' EJR request at 1.
[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

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

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

A. Wage Index

1. Rural Floor Adjustment

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

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in some urban hospitals being paid less than the average rural hospital in the

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[4] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww (d)(3)(E) requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

[5] 42 U.S.C. § 1395ww(d)(2)(A)-(D).

[6] 42 U.S.C. § 1395ww(d)(3)(E).

[7] *See* 84 Fed. Reg. at 42300. The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. Under 42 U.S.C. § 1395ww(d)(3)(E) beginning with FY 2005, the Secretary delineated hospital labor market areas based on OMB-established Core-Based Statistical Areas ("CBSAs"). The current statistical areas (which were implemented beginning with FY 2015) are based on revised OMB delineations issued on February 28, 2013. Bulletin No. 13–01.

[8] 84 Fed. Reg. at 42300.

[9] *Id.*

[10] *Geisinger Community Med. Ctr. v. Secretary of DHHS*, 794 F. 3d 383, 386 (3d Cir. 2015).

state.[11] To correct this problem, in § 4410(a) of the Balanced Budget Act of 1997 ("BBA"), Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state.[12] Specifically, BBA § 4410(a) states:

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

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

2. Geographic Reclassification and "Section 401" Hospitals

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

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

> (i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary ***shall treat the hospital as being located in the rural***

[11] H.R. Rep. No. 105-149, at 1305 (1997).
[12] Pub. L. 105-33, § 4410(a), 111 Stat. 251, 402 (1997) (uncodified as 42 U.S.C. § 1395ww note).
[13] *Id.*
[14] *Robert Wood Johnson Univ. Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).
[15] 42 U.S.C. § 1395ww(d)(10)(D)(v).
[16] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999) (codified as 42 U.S.C. § 1395ww(d)(8)).

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

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

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

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

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

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

In the FFY 2019 IPPS proposed Rule published on May 7, 2018,[20] the Secretary noted that there had been numerous studies, analyses and reports identifying disparities between the wage index values for individual hospitals and wage index values among different geographic areas and ways to improve the Medicare wage index, as well as public comments made during prior rulemaking.[21] The Secretary explained that the current wage index methodology relies on labor markets that are based on statistical area definitions (core-based statistical areas ("CBSAs")) established by OMB. Hospitals are grouped in either an urban labor market (that is a metropolitan statistical area ("MSA") or metropolitan division) or a statewide rural labor market (any area of a State that is not defined as urban). The current system relies on hospital data submitted to CMS, rather than data reflecting broader labor market wages such as data from the Bureau of Labor Statistics.[22]

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

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

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[20] 83 Fed. Reg. 20164 (May 7, 2018).
[21] *Id.* at 20372. For a discussion of those studies and references to previous requests for comments in the Federal Register, *see* 83 Fed. Reg. at 20372-76.
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.* at 20377.

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

In the FFY 2020 IPPS final rule published on August 15, 2019, the Secretary finalized several changes to the hospital wage index.[26] The Secretary noted that many responses had been received as a result of the FFY 2018 IPPS proposed rule's request for comments from stakeholders regarding the wage index. Those responses reflected common concerns that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals. In addition, respondents also expressed concern that the calculation of the rural floor has allowed a limited number of States to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities.[27]

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

1. The policy "to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under [42 U.S.C. § 1395ww(d)(8)(E)] (as implemented at § 412.103)";[31] and

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[26] The Secretary announced the proposed changes in the FFY IPPS proposed rule published on May 7, 2019. 84 Fed Reg. 19158, 19396-98 (May 3, 2019).
[27] 84 Fed. Reg. 42044, 42325 (Aug. 16, 2019).
[28] *See generally id.* at 42336-42339.
[29] 42 C.F.R. § 412.103 states in relevant part that:

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

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

2. The policy, "for purposes of applying the provisions of [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under [42 U.S.C. § 1395ww(d)(8)(E)] (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in [42 U.S.C. § 1395ww](d)(8)(C)(iii)]."[32]

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

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

In the FFY 2020 IPPS proposed rule,[33] the Secretary had announced his proposal to remove urban reclassifications from the calculation of the rural floor under 42 U.S.C. § 1395ww(d)(8)(E) (as implemented by 42 C.F.R. § 412.103). In the FY 2020 IPPS final rule, the Secretary implemented that proposal stating that he believes that the proposed calculation methodology is permissible under the 42 U.S.C. § 1395ww(d)(8)(E) and BBA § 4410(a) which established the rural floor.[34] The Secretary maintains that § 1395ww(d)(8)(E) does not specify where the wage data of reclassified hospitals must be included. Therefore, the Secretary believes that he has the discretion to exclude wage data of reclassified hospitals calculation of the rural floor. Furthermore, the Secretary explained that BBA § 4410(a) does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation. Therefore, the Secretary believes that he has the discretion BBA § 4410(a) to exclude the wage data of hospitals reclassified under § 1395ww(d)(8)(E) from the calculation of the rural floor.[35]

The Secretary contends that this policy is necessary and appropriate to address the unanticipated effects of rural floor reclassification on the rural floor and resulting wage index disparities, including the alleged manipulation of the rural floor by certain hospitals. The Secretary concludes that the inclusion of reclassified hospitals in the rural floor calculation has been an unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals.[36]

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

Pursuant to the FFY 2020 IPPS final rule, the Secretary would continue to calculate the rural floor based on the physical non-MSA area of the state, which is the same rural area to which a hospital is reclassified under § 1395ww(d)(8)(E). However, for purposes of calculating the rural floor wage index for a state, the Secretary would not include in the rural area the data of hospitals that have been reclassified as rural under § 1395ww(d)(8)(E). The Secretary pointed

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

out that the legislative intent of the rural floor was to correct the anomaly of some urban hospitals being paid less than the average rural hospital in their States.[37]

The Secretary had found that, under the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural. The Secretary explained that while urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification, other states with high wage urban hospitals using 42 C.F.R. § 412.103 reclassification to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality. The Secretary believes that, excluding the data of hospitals that reclassify as rural under § 1395ww(d)(8)(E) from the rural floor wage index is necessary and appropriate to address the unanticipated effects of the rural floor reclassifications on the rural floor and the resulting wage index disparities.[38]

The Secretary contends that his reimbursement calculation is permissible under 42 U.S.C. § 1395ww(d)(8)(E) (as implemented by 42 C.F.R. § 412.103) and BBA § 4410(a)). The statute does not specify where the wage data of reclassified hospitals must be included. Therefore, the Secretary believes that he has the discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. In addition, the Secretary points out, BBA § 4410(a) does not specify how the rural floor wage index is to be calculated or what data is to be included in the calculation. Consequently, the Secretary believes that he has the discretion under BBA § 4410(a) to exclude the wage data of hospitals reclassified under § 1395ww(d)(8)(E) from the calculation of the rural floor.[39]

Providers' Position

The Providers are challenging their IPPS payments for the FFY 2020 on the grounds that those payments were (and continue to be) improperly understated because the Secretary unlawfully excluded from the calculation of the rural floor the data of urban hospitals that have been reclassified to rural status. Specifically, the Providers contend that the Secretary's allegedly invalid exclusion of the reclassified wage data from the rural floor calculation caused the rural floor value to be lower that it would have otherwise been, which improperly understated the Providers' FFY 2020 IPPS payments.

The Providers explain that in the FFY 2020 IPPS Final Rule, the Secretary sought to address what he called "wage index disparities" by adopting a number of new policies that would impact AWI values and the IPPS Medicare reimbursement that an IPPS hospital receives.[40] The policy in dispute in this case alters how the rural floor is calculated such that data of urban hospitals that reclassified to rural status under 42 C.F.R. § 1395ww(d)(8)(E), are excluded from the rural floor

[37] *Id.* at 42334.
[38] *Id.*
[39] *Id.*
[40] *Id.* at 42326,

calculation (Rural Floor Data Exclusion Policy). In the FFY 2020 IPPS Final Rule, the Secretary asserted that he had the authority to implement this Rural Floor Data Exclusion Policy under 42 U.S.C. § 1394ww(d)(8)(E)—the reclassification statute where the "Secretary shall treat the [urban to rural reclassified] hospital as being located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located"—and the rural floor statutes—42 U.S.C. § 1395ww(d)(8)(c)(iii) and Section 4110(a) of Public Law 105-33—because 42 U.S.C. § 1395ww(d)(8)(E) does not specify where the wage data reclassified hospitals must be included and that the rural floor statue does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation.[41]

The Providers contend that the Secretary lacks the authority to excluded from the rural floor calculation the wage data of urban hospitals that have been reclassified to rural status under 42 U.S.C. § 1395ww(d)(8)(E), in the manner set forth in the FFY 2020 IPPS Final Rule. Consequently, the Providers are challenging the reduction to their IPPS payments as the result of the Rural Floor Data Exclusion policy on several grounds, including, but not limited to, that it exceeds statutory authority, is otherwise inconsistent with the law, is arbitrary and capricious, is not supported by the applicable rulemaking record, is an abuse of discretion and otherwise defective both procedurally and substantively.

Decision of the Board

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

A. Jurisdiction and Request for EJR

As previously noted, all of the participants appealed from the FFY 2020 IPPS final rule.[42] The Board has determined the participants' documentation for each of the groups shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[43] 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.

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

The Board notes that the relevant *cost reporting periods* for the participants in these group appeals that are impacted by the FFY 2020 IPPS final rule begin well after January 1, 2016 and, as such, are subject to the newly-added 42 C.F.R. § 405.1873 and related revisions to 42 C.F.R.

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[41] *Id.* at 42332.
[42] The CMS Administrator has determined that a Federal Register notice is a final determination from which a provider may appeal to the Board. *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*), rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015).
[43] *See* 42 C.F.R. § 405.1837.

§ 413.24(j) regarding submission of cost reports.[44] However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether any of the relevant participants' cost reports included an appropriate claim for the specific item under appeal, *presumably because any such potential issue is not yet ripe*. In this regard, the Board notes that the participants are appealing the FFY 2020 Federal Register Notice and the cost reports impacted by such notice have not yet been filed to trigger § 413.24(j)'s general substantive payment requirement for cost reports.[45]

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to treat Section 401 hospitals as not being located in a rural area for the purpose of the rural floor calculation and to assign a wage index to urban hospitals that was lower than the wage index assigned to rural hospitals was made through notice and comment in the form of an uncodified regulation.[46] Specifically, in the preamble to FFY 2020 IPPS final rule, the Secretary announced the following two policies to address wage index disparities:

1. The policy "to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under [42 U.S.C. § 1395ww(d)(8)(E)] (as implemented at § 412.103)";[47] and

2. The policy, "for purposes of applying the provisions of [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under [42 U.S.C. § 1395ww(d)(8)(E)] (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in [42 U.S.C. § 1395ww](d)(8)(C)(iii)]."[48]

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

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural

[44] *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015).
[45] *See* 80 Fed. Reg. at 70556, 70569-70.
[46] *See* 84 Fed. Reg. 42044, 42325-36 (section entitled "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals").
[47] 84 Fed Reg. at 42336.
[48] *Id.*

> floor without including the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E) . . . (as implemented at [42 C.F.R.] § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section § [1395ww](d)(8)(C)(iii) . . . to remove the wage data of urban hospitals reclassified as rural under section 1395ww](d)(8)(E) . . . (as implemented at § 412.103) from the calculation of ''the wage index for rural areas in the State in which the county is located'' referred to in section [1395ww](d)(8)(C)(iii) . . . .[49]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulation on Rural Reclassification." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[50]

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

D. Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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[49] *Id.*

[50] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

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

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Rural Reclassification as published in the FFY 2020 IPPS final rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

8/13/2020

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
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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Noridian Healthcare Solutions c/o Cahaba
Safeguard Administrators (J-E)
Lorraine Frewert
Appeals Coordinator, JE Provider Audit
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Jurisdictional Decision***
Cottage Health CY 2007 Standardized Payment Amount CIRP Group
Case No. 20-0590GC

Dear Ms. Goron and Ms. Frewart,

The Provider Reimbursement Review Board ("Board") has reviewed the above- captioned common issue related party ("CIRP") group appeal on its own motion. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Background

On January 9, 2020, the Provider filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted:

> The Provider(s) contend(s) that the MAC's determination for their standardized payment amount was calculated improperly and set too low based on erroneous methodology.
>
> Under the Inpatient Prospective Payment System, hospitals are paid a fixed amount for each Medicare beneficiary that they treat, "regardless of the actual operating costs they incur." *See Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 133 S. Ct. 817, 822, 184 L. Ed. 2d 627 (2013). This fixed amount is calculated by starting with ***a base rate*** that is then adjusted in various ways for each specific beneficiary at each specific hospital. See 42 U.S.C. § 1395ww(d)(2).
>
> The ***base rate*** used 1981 hospital cost reporting data, and was first developed in 1983 for use in the 1984 fiscal year. The ***base rate*** was partially determined by the average cost-per-discharge. 42 U.S.C. § 1395ww(d)(2). The base year 1981 data did not distinguish between patient discharges and patient transfers. Both were classified as discharges. Therefore, the 1981 data over-

> counted discharges, by including both discharges and transfers in the baseline data.
>
> The result of this error was to spread total operating costs over an artificially high number of discharges, thereby yielding a lower average cost-per-discharge. This in turn lead to a ***base rate*** that was lower than it would have been had the total number of patient discharges been accurately computed. As this error in the ***base rate*** has never been corrected, the standardized payment amount has been lower than it should have been in every year since 1984. Accordingly, for the reason stated above, provider hereby appeals the standardized payment amount for the years at issue in this cost report.[1]

There is only one participant in this CIRP group appeal and it appealed from Revised Notice of Program Reimbursement ("RNPR")—Participant #1, Santa Barbara Cottage Hospital ("Cottage Hospital").

The Notice of Reopening of Cost Report (October 5, 2015) for Cottage Hospital states that the cost report was reopened:

> To determine the allowability of the additional eligible Medicaid days submitted by the Provider.[2]

Cottage Hospital received its RNPR on July 17, 2019. The RNPR included adjustments for "Medicaid Title 19 DSH days … to agree with provider's submitted updated DSH listing totals."

Board Decision

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

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

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

[1] *Model Form B – Group Appeal Request* (January 9, 2020) (emphasis added).
[2] *Model Form B – Group Appeal Request* (January 9, 2020).

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

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

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

The Board finds that it does not have jurisdiction over Cottage Hospital (which is the sole participant in this CIRP group appeal) because Cottage Hospital appealed from an RNPR that did *not* adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The reopening in this case was a result of the Provider's request to submit additional Medicaid Eligible days for DSH calculations. The audit adjustments associated with the RNPRs under appeal clearly only adjusted the DSH adjustment payments for additional Medicaid Eligible days added to the Medicaid fraction used in the calculation of those DSH adjustment payments. The Notice of Reopening explicitly stated that the purpose of the reopening was "to determine the allowability of the additional eligible Medicaid days submitted by the Provider." In other words, the determination was only being reopened to include additional Medicaid Eligible days. Since the only "matters" specifically revised in the RNPR were adjustments related to additional Medicaid Eligible days as it relates to the DSH adjustment payments, the Board does not have jurisdiction over the standardized amount issue for the participant in the subject group appeal pursuant to 42 C.F.R. § 405.1889(b). The Board's interpretation and application § 405.1889 is consistent with how Courts have applied and interpreted it.[4]

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[3] 42 C.F.R. § 405.1889(b)(1).

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

In conclusion, the Board hereby dismisses Santa Barbara Cottage Hospital from the CIRP group appeal as it does not have the right under 42 C.F.R. § 405.1889 to appeal the standardized payment amount issue based on the RNPR at issue. As there are no participants remaining, the Board hereby closes Case No. 20-0590GC 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
Susan A. Turner, Esq.

FOR THE BOARD:

8/14/2020

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Lorraine Frewert
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Fargo, ND 58108-6782

RE: ***Jurisdictional Decision***
Cottage Health CY 2011 Standardized Payment Amount CIRP Group
Case No. 20-1554GC

Dear Ms. Goron and Ms. Frewart,

The Provider Reimbursement Review Board ("Board") has reviewed the above- captioned common issue related part ("CIRP") group appeal on its own motion. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Background

On April 7, 2020, the Provider filed this group appeal with the Provider Reimbursement Review Board ("Board"). The group issue statement as submitted:

> The Provider(s) contend(s) that the MAC's determination for their standardized payment amount was calculated improperly and set too low based on erroneous methodology.
>
> Under the Inpatient Prospective Payment System, hospitals are paid a fixed amount for each Medicare beneficiary that they treat, "regardless of the actual operating costs they incur." *See Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 133 S. Ct. 817, 822, 184 L. Ed. 2d 627 (2013). This fixed amount is calculated by starting with ***a base rate*** that is then adjusted in various ways for each specific beneficiary at each specific hospital. See 42 U.S.C. § 1395ww(d)(2).
>
> The ***base rate*** used 1981 hospital cost reporting data, and was first developed in 1983 for use in the 1984 fiscal year. The ***base rate*** was partially determined by the average cost-per-discharge. 42 U.S.C. § 1395ww(d)(2). The base year 1981 data did not distinguish between patient discharges and patient transfers. Both were classified as discharges. Therefore, the 1981 data over-

> counted discharges, by including both discharges and transfers in the baseline data.
>
> The result of this error was to spread total operating costs over an artificially high number of discharges, thereby yielding a lower average cost-per-discharge. This in turn lead to a ***base rate*** that was lower than it would have been had the total number of patient discharges been accurately computed. As this error in the ***base rate*** has never been corrected, the standardized payment amount has been lower than it should have been in every year since 1984. Accordingly, for the reason stated above, provider hereby appeals the standardized payment amount for the years at issue in this cost report.[1]

There is only one participant in this CIRP group appeal and it appealed from Revised Notice of Program Reimbursement ("RNPR")—Participant #1, Santa Barbara Cottage Hospital ("Cottage Hospital").

The Notice of Reopening of Cost Report (October 6, 2015) for Cottage Hospital states the cost report was reopened relative to an issue related to the disproportionate share hospital ("DSH") payment adjustment:

> To determine the allowability of the additional eligible Medicaid days submitted by the Provider.[2]

Cottage Hospital received its RNPR on November 22, 2019. The RNPR included DSH adjustments related to these Medicaid eligible days.

Board Decision

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

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

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

[1] *Model Form B – Group Appeal Request* (April 7, 2020) (emphasis added).
[2] *Model Form B – Group Appeal Request* (April 7, 2020).

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

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

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

The Board finds that it does not have jurisdiction over Cottage Hospital (which is the only participant in this CIRP group appeal) because Cottage Hospital appealed from an RNPR that did not adjust the standardized payment amount (*i.e.*, the base rates underling the DRG rates published annually in the Federal Register).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The Notice of reopening in this case identified additional Medicaid eligible days and these days are used in the Medicaid fraction of the DSH adjustment calculation. The audit adjustments associated with the RNPRs under appeal adjusted Medicaid eligible days which is not related to the standardized payment amount issue. Since the matters specifically revised in the RNPR did ***not*** adjust the standardized payment amount, the Board does not have jurisdiction over Cottage Hospital, the only participant in the subject CIRP group appeal. The Board notes that its interpretation and application § 405.1889 is consistent with how Courts have applied and interpreted it.[4]

In conclusion, the Board hereby dismisses Santa Barbara Cottage Hospital from the CIRP group appeal as it does not have the right under 42 C.F.R. § 405.1889 to appeal the standardized payment amount issue based on the RNPR at issue. As there are no participants remaining in the

---

[3] 42 C.F.R. § 405.1889(b)(1).

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

CIRP group, the Board hereby closes Case No. 20-1554GC 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.
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Robert A. Evarts, Esq.
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FOR THE BOARD:

8/14/2020

X Clayton J. Nix

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