DEPARTMENT OF HEALTH & HUMAN SERVICES

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

VIA ELECTRONIC DELIVERY

Mr. Richard Reid
The Rybar Group, Inc.
3150 Owen Road
Fenton, MI 48430

Ms. Cecile Huggins
Audit Supervisor, Provider Cost Report Appeals
Palmetto GBA
Internal Mail Code 380
P.O. Box 100307
Camden, SC 29202-3307

RE: Fayette Medical Center
Provider No.: 01-0045
FYE – 09/30/2016
PRRB Case No.: 21-1541

Dear Mr. Reid and Ms. Huggins:

The above-captioned appeal was submitted to the Provider Reimbursement Review Board ("Board") via OH CDMS on August 9, 2021 and was assigned case number 21-1541. The pertinent facts of the case and the Board's decision are set forth below.

Pertinent Facts:

Upon review of the appeal request, the Provider indicated that the subject appeal is based on the Volume Decrease Adjustment ("VDA"). The document uploaded by the Provider as the final determination is an email from the Medicare Contractor ("MAC") to the Provider and the Representative indicating the changes made to the VDA adjustment. The Provider identified the final determination date as June 19, 2021; however, the date of the MAC's email is June 19, 2020.

Decision of the Board:

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

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

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

Pursuant to Board Rule 7.1.2.5, Other Final Determination. For any other final determination not listed above, identify the specific final determination being appealed and the authority granting the Board's jurisdiction over the dispute."

In addition, Board Rule 6.1.1 states, in part, "The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b)."

Including the actual determination being appealed with the appeal request is critical for a myriad of reasons, including to determine whether the Provider met the claim filing requirements specified in 42 C.F.R. § 405.1835. Because the Provider failed to submit the required copy of the final determination under appeal in the subject case, the Board finds that the Provider did not meet the regulatory requirements for filing an appeal before the Board. Accordingly, the Board finds dismissal is appropriate under § 405.1835(b) and Board Rules and hereby dismisses and closes Case No. 21-1541.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

<u>Board Members:</u>

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

FOR THE BOARD:

9/2/2021

X Gregory H. Ziegler

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

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Expedited Judicial Review Determination***
19-1938G Southwest Consulting CY 2013 DSH SSI Fraction Part C Days Group 3 Group
19-2039G Southwest Consulting CY 2013 DSH Medicaid Fraction Part C Days III Group

Dear Mr. Newell:

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

On October 26, 2020, the Providers in the above-referenced CIRP group appeal filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Request, and then grant it in part and deny it in part, is set forth below.

Effect of COVID -19 on Board Operations

By letter dated April 15, 20200, the Board sent the Group Representative notice for these groups that the 30-day time period for issuing an EJR had been stayed consistent with Board alert 19. As explained below, that stay remains in effect. On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On October 29, 2020, subsequent to the submission of the EJR request, the Board notified you of the Issue in relevance of Alert 19 to the

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

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

Statutory and Regulatory Background

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[2] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[3]

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

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[2] of Health and Human Services.
[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*

With the creation of Medicare Part C in 1997,[5] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[6]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . .[7]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[8] In response to a comment regarding this change, the Secretary explained that:

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

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

[6] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[7] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[8] 69 Fed. Reg. at 49099.

> regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[9]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[10] In that publication, the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[11] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[14] In *Allina Health Services v. Price* ("*Allina II*"),[15] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[16] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

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[9] *Id.* (emphasis added).
[10] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[11] *Id.* at 47411.
[12] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

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

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new

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[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.
[21] *Id*.

> final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[22]

Provider's Request for EJR:

The Providers within the CIRP group appeals are challenging their Medicare reimbursement for the fiscal year 2013 cost reporting period. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[23] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[24] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[25] As such, the Providers conclude that the Board is "required" to grant EJR.[26]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[27] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[28]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without

[22] CMS Ruling 1739-R at 6-7.
[23] EJR Request at 1.
[24] *Id*. at 1.
[25] *Id*.
[26] *Id*. at 1-2.
[27] *Id*. at 11-12.
[28] *Id*. at 21.

> violating provisions of the Medicare statute that are binding on the Board here.[29]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[30]
>
> . . . .
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> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[31]

<u>Board's Decision and Analysis</u>:

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

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

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for*

[29] *Id*. at 14.
[30] *Id*. at 14.
[31] *Id*. at 17.

the Ruling, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after this CIRP group was established).

Board's Authority

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

The Board's analysis is detailed below.

Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[32, 33]

The remaining[34] Providers included in the instant EJR requests filed appeals of either original Notices of Program Reimbursement ("NPRs") or revised NPRs ("RNPRs") in which the Medicare contractor settled cost reporting periods ending in 2013.[35]

For Providers with appeals filed from original NPRs for cost reporting periods ending on December 31, 2008 and which began before January 1, 2016, CMS Ruling CMS-1727-R involves dissatisfaction with the Medicare Contractor determinations. The Board determines whether the participants' appeals involved with the instant EJR requests are governed by CMS-1727-R.[36]

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[32] 42 C.F.R. § 405.1835(a).

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

[34] The Board previously dismissed from Case No. 19-1938GC the participant, Thomas Jefferson University Medical Center, the only RNPR appeal, in a decision dated April 16, 2021.

[35] There is only one provider (in both appeals) with a 12/31/2013 FYE, SUNY Health Sciences. The provider only transferred the 1/1/-9/30 challenge to the Medicaid fraction appeal, and the Medicare fraction appeal is an appeal of the SSI fraction which for a 12/31/213 provider only includes discharges for 10/1/2012 09/30/2013. Therefore, there is no challenge for post 10/1/2013 in either fraction appeal.

[36] Under ruling 1727-R, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

For Providers with appeals filed from RNPRs issued after August 21, 2008, the Board only has jurisdiction to hear a provider's appeal of matters that the Medicare contractor specifically revised within the RNPR[37] and the Board previously dismissed the sole participant appealing from an RNPR from Case No. 19-1938GC.[38]

The participants that comprise the group appeal within this EJR request have filed appeals involving calendar year 2013. The Board has determined that the remaining participants[39] have fiscal years governed by the holding in Bethesda or CMS Ruling CMS-1727-R. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds $50,000 in each appeal, as required for a group appeal. The appeals of the remaining particpants were timely filed and included the issue within the instant EJR request. Based on the above the Board finds that it has jurisdiction for the remaining Providers in the above-captioned appeals. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

<u>*Medicare Part C Days Issue*</u>

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[40] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[41] *i.e*., the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[42] To date, CMS has yet to issue its new final rule.[43]

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

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[37] *See* 42 C.F.R. § 405.1889(b)(1) (2008).
[38] *See supra* note 34.
[39] *See supra* note 34.
[40] (Emphasis is added.)
[41] CMS Ruling 1739-R at 1-2.
[42] Id. at 2.
[43] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[44] Accordingly, the Board will issue, under separate cover, a remand for the remaining group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

Validity of CMS Ruling 1739-R

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

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[45]

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

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

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

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

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

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[50] Here, the remaining Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeals under Case Nos. 19-1938GC and 19-2039GC, except for Thomas Jefferson University Hospital, which the Board previously dismissed from Case No. 19-1938GC by letter dated April 16, 2021 (and for which the Board must deny the EJR request in its entirety);[51]

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

[47] *See Southwest* at 6-7.
[48] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[49] *See* CMS 1739-R at 8.
[50] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).
[51] *See supra* note 34.

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

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

Board Members Participating:

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For the Board:

9/7/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
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cc: Wilson Leong, FSS
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Determination***
Cleveland Clinic 2007 SSI Fraction Medicare Advantage Days CIRP Group
Case No. 13-1625GC

Dear Ms. Goron and Ms. Cummings:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal referenced above. The background of the case, the pertinent facts and the Board's determination are set forth below.

Background:

This group appeal request was filed on April 15, 2013. The group currently has 10 Providers – 3 of which are appealing from both original and revised Notices of Program Reimbursement ("NPR"). 3 of those Providers were initially part of Case No. 20-1515GC, Cleveland Clinic Foundation CY 2007 DSH SSI Fraction Medicare Managed Care Part C Days Group – South Pointe Hospital (36-0144), Euclid Hospital (36-0082), and Cleveland Clinic (36-0180). On May 22, 2020, the Providers' representative in 20-1515GC, Healthcare Reimbursement Services, Inc. ("HRS"), requested that the appeal be incorporated with Case No. 13-1625GC. The Board incorporated these appeals and closed Case No. 20-1515GC on May 29, 2020.

Pertinent Facts:

South Pointe Hospital (36-0144) FYE 12/31/2007

South Point Hospital has appealed from both an original and revised NPR. It requested to be directly added to this group, Case No. 13-1625GC on October 19, 2012, based on its *original* NPR. Subsequently, the Provider requested that the Medicare Contractor reopen its cost report. On October 16, 2015, the Medicare Contractor issued a Notice of Intent to Reopen which was issued "[t]o update the SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 10/16/2015." The Medicare Contractor issued the Provider's revised NPR on October 2, 2019, which included the following adjustments:

- Audit Adjustment 1: was made "[t]o update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."
- Audit Adjustment 3: was made to "update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."

Euclid Hospital (36-0082) FYE 12/31/2007

Euclid Hospital has appealed from both an original and revised NPR. It requested to be directly added to this group, Case No. 13-1625GC on October 23, 2012, based on its *original* NPR. Subsequently, the Provider requested that the Medicare Contractor reopen its cost report. On October 16, 2015, the Medicare Contractor issued a Notice of Intent to Reopen which was issued "[t]o update the SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 10/16/2015." The Medicare Contractor issued the Provider's revised NPR on October 2, 2019, which included the following adjustments:

- Audit Adjustment 1: was made "[t]o update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."
- Audit Adjustment 3: was made to "update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."

Cleveland Clinic (36-0180) FYE 12/31/2007

Cleveland Clinic has appealed from both an original and revised NPR. It requested to be directly added to this group, Case No. 13-1625GC on October 25, 2012, based on its *original* NPR. Subsequently, the Provider requested that the Medicare Contractor reopen its cost report. On October 16, 2015, the Medicare Contractor issued a Notice of Intent to Reopen which was issued "[t]o update the SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 10/16/2015." The Medicare Contractor issued the Provider's revised NPR on October 2, 2019, which included the following adjustments:

- Audit Adjustment 1: was made "[t]o update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."
- Audit Adjustment 3: was made 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.

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

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

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

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

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

> (a) *Right to hearing on final contractor determination*. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if—
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under §405.1803. *Exception*: **If a final contractor determination is**

> **reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§405.1887(d), 405.1889(b), and the ''Exception'' in §405.1873(c)(2)(i)).[1]

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

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

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

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

[1] (Bold emphasis added.)
[2] 42 C.F.R. § 405.1889(b)(1).

> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[3]

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

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[5]

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

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

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

---

[3] (Emphasis added.)
[4] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[5] (Emphasis added.)
[6] (Emphasis added.)

In other words, the determinations were only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPRs were adjustments to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the ***revised*** NPR appeals of the DSH Part C days issue by South Pointe Hospital, Euclid Hospital, and Cleveland Clinic Hospital because they had no right under 42 C.F.R. § 405.1889(b) (as referenced in 42 C.F.R. § 405.1835(a)) to appeal the issue from the RNPR. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[7]

In conclusion, the ***revised*** NPR appeals of these three participants are dismissed from the CIRP group as they do not have the right to appeal the revised NPRs at issue under 42 C.F.R. § 405.1889 for the DSH Part C days issue. The remaining providers in the appeal will be subject to remand pursuant to CMS Ruling 1739-R, under separate cover. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

<u>Board Members</u>:
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For the Board:

9/8/2021

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination***
Hall Render CY 2012-2014 DSH SSI Dual Eligible Days Group
Case No. 20-1520G

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above Providers' request for expedited judicial review ("EJR Request") received June 23, 2021 for the above-referenced *optional* group case. On July 22, 2021, the Board requested the Group Representative to review the participants for compliance with the rules for mandatory common issue related party ("CIRP") groups and, in particular, confirm whether confirm whether Participant #3, NorthShore University Health System (Prov. No. 14-0010, FYE 9/30/14) belongs in a CIRP group as required by the regulaton, 42 C.F.R. § 405.1837(b). On August, 11, 2021, the Group Representative responded to the Board's July 22, 2021 rquest and confirmed that the participants are in compliance with the CIRP group rules. In particular, with respect to Particpant #3, the Group Representative confirmed that, for CY 2014, there was another related provider, Skokie Hospital (Prov. No. 14-0100), but that no CIRP group was needed (*i.e.*, that neither Skokie Hospital nor any other NorthShore Heath System hospital from 2014 would be puruing this issue for CY 2014). As a result, of this representation, Participant #4 may remain in the optional group; however, *be advised that the North Shore Heath System (including Skokie Hospital) may not further puruse this issue for CY 2014 (whether in an individual appeal, a CIRP group appeal or another optional group)*.[1] As the EJR request for Case No. 20-1520G is now complete, the Board has set forth below its determination regarding the EJR request.

[1] In the final Board Rules published in the May 23, 2008 Federal Register, the Secretary stated that:

> Our interpretation of the statute is that commonly owned or operated providers must bring ''a'' group appeal on the same issue. If the Congress had intended to permit separate group appeals, it could have said that the appeal must be brought by ''one or more groups.'' Therefore, at this time, we believe we are constrained to require that commonly owned or operated providers bring only one group appeal for the same issue (regarding cost reporting periods ending in the same calendar year).

73 Fed. Reg. 30190, 30213 (May 23, 2008). To that end, the Secretary enacted the regulation, 42 C.F.R. § 405.1837(b), which requires that:

> (1) Mandatory use of group appeals.
> (i) Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.

Issue for which EJR is Requested:

The Providers,in the above-referenced group appeal are requesting EJR for the following issue:

> The days at issue in these appeals are days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in these appeals is whether the Intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction" for purposes of calculating the Provider's [Disproportionate Share Hospital ("DSH")] payment, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."
>
> The Providers respectfully assert that under the rules of statutory construction CMS is *compelled to interpret "entitlement to SSI" benefits to include all inpatients who were eligible for and/or enrolled in the SSI program at the time of their hospitalization* ***and***, further, to *furnish Providers with a listing of those SSI Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare Act*. Furthermore, [t]he Providers seek a ruling that CMS has failed to provide the them with adequate information to allow them to check and challenge CMS'[] disproportionate patient percentage ("DPP") calculations. The Providers are entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173. . . . Because the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of the hospital's Medicare patients who are enrolled in SSI and/or eligible for SSI benefits along with their corresponding SSI status codes, and does not give the Providers any meaningful means of

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The Board notes that NorthShore University Health System consists of multiple hospitals, which would require the use of a common issue related party group should two or more providers within the organization elect to appeal the disproportionate share supplement security income (SSI) dual eligible days issue for calendar year 2014, Currently, only NorthShore University Health System (Prov. No. 14-0010, FYE 9/30/14) has appealed the issue which is currently the subject of this optional group appeal, Case No. 20-1520G. However, in the future, if any of other hospitals in the NorthShore University Health System raises the issue that is the subject of this EJR request they are barred from doing so for CY 2014 because one member of the organization (Participant #3) has: (1) appealed the issue for 2014; (2) confirmed no other member in the origaniation would pursue this issue for CY 2014; and (3) based on this representation, was allowed to remain int the optional group where it received a final determination from the Board with respect to that issue (as set forth herein). As noted by the Secretary in the May 23, 2008 Federal Register final rule, commonly owned or controlled providers must file a single group appeal for the same issue within a calendar year.

> challenging the SSI days chosen by CMS to be used in Provider's DPP calculations, CMS continually violates its § 951 mandate . . . .[2]

<u>Medicare Disproportionate Share Hospital (DSH) Payment Background</u>:

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

> (2) *First computation: Federal fiscal year.* For each month of the Federal <u>fiscal year</u> in which the <u>hospital</u>'s cost reporting period begins, <u>CMS</u> –
>
> (i) Determines the number of <u>patient</u> days that –
>
> (A) Are associated with <u>discharges</u> occurring during each month; and
>
> (B) Are furnished to <u>patients</u> who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those <u>patients</u> who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under <u>paragraph (b)(2)(ii)</u> of this section by the total number of days that –
>
> (A) Are associated with <u>discharges</u> that occur during that period; and
>
> (B) Are furnished to <u>patients</u> entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

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[2] EJR Request at 2-3 (emphasis added).
[3] 42 C.F.R. Part 412.
[4] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[5] (Emphasis added.)
[6] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).

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

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[7] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[8] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[9]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[10] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[11]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[12] and may terminate,[13] suspend[14] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[15] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

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

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

5. The individual becomes a resident of a public institutions or prison.[20]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[21]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[22] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[23] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[24] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[25] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[26]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[27]

[20] 20 C.F.R. § 416.211.
[21] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[22] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[23] *Id.*
[24] *Id.*
[25] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[26] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[27] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[28] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[29] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[30]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[31] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[32]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[33] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[34] CMS responded in detail to this comment and explained that CMS interprets

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individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[28] CMS-1498-R at 5.

[29] *Id.*

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

[31] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

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

[33] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

[34] *Id.* at 50280.

SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[35] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[36] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[37]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[38] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[39] In the FY 2111 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[40]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[41]

As a result of the Rulings, new regulation, and new data match process, CMS calculated SSI percentages for the Providers for all of fiscal years at issue in this CIRP group appeal.[42] The Providers have appealed original NPRs a based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

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[35] *Id.* at 50280-50281.
[36] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[37] *Id.* at 50285.
[38] CMS-1498-R at 6-7, 31.
[39] *Id.* at 28, 31.
[40] 75 Fed. Reg. at 24006.
[41] CMS-1498-R2 at 2, 6.
[42] CMS published the SSI ratios for FY 2012 on or about June 12, 2014. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

Providers' Request for EJR:

The Providers assert that, under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration ("SSA") for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[43]

The Providers note that, in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the FY 2011 IPPS Final Rule that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[44] Thus, the Providers allege the exclusion of the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the DSH statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' disproportionate patient percentage ("DPP") calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA").[45]

Decision of the Board:

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

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[43] 75 Fed. Reg. at 50275-86.
[44] *Id.* at 50281.
[45] Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).

A. Jurisdiction

The participants that comprise the group appeal within this EJR determination, have filed appeals involving fiscal years 2012-2014.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the DSH SSI Dual Eligible Days issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[46] 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.[47]

On August 21, 2008, new regulations governing the Board were effective.[48] 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*").[49] 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.[50]

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

[46] 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.).
[47] *Bethesda*, 108 S. Ct. at 1258-59.
[48] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[49] 201 F. Supp. 3d 131 (D.D.C. 2016).
[50] *Id.* at 142.

Based on its review of the record, the Board finds that each of the participants in the this case, which filed from NPRs beginning ***prior to*** January 1, 2016, filed timely and proper appeals. In this regard, the Board finds that the Providers are governed by CMS Ruling CMS-1727-R and that the above Providers' appeals are permitted as they are challenging the substantive and procedural validity of a regulation.

The participants' documentation in the EJR request shows that the estimated amount in controversy exceeds $50,000 in the group, as required for a group appeal.[51] 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. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a *revised* data match.[52] The Secretary also stated in the Ruling that, where cost reports had not been settled, those providers SSI fraction would be calculated using the *revised* data match process to be published through rulemaking.[53]

Contemporaneous with CMS Ruling 1498-R[54] the Secretary published a proposed IPPS rule[55] which proposed to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the 2011 Final IPPS Rule in which the Secretary explained that:

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

51 *See* 42 C.F.R. § 405.1837.
52 CMS Ruling 1498-R at 27.
53 *Id.* at 31.
54 *Id.* at 5.
55 75 Fed. Reg. 23852, 24002-07.

> matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[56]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[57]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[58]

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

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[59] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes

[56] 75 Fed. Reg. at 50277.
[57] (Medicare) Enrollment Database.
[58] 75 Fed. Reg. at 50285.
[59] 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 . . . ."

used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this CIRP group appeal.

C. Board's Decision Regarding the EJR Request

The Board makes the following findings:

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

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

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

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

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation (as adopted in the preamble to the 2011 Final IPPS 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 years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating:

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Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.
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For the Board:

9/9/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Pam VanArsdale, NGS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision – No Right to Appeal & Duplicate CIRP Group***
Southwest Consulting UPMC Revised NPR 2010 DSH Medicare Advantage Part C Days CIRP
Case No. 17-2285GC

Dear Messrs. Newell and Snyder:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in the common issue related party ("CIRP") group under Case No. 17-2285GC. The Board's decision is set forth below.

Background

There is only one participant in this group appeal – UPMC Magee Women's Hospital (PN 39-0114, 6/30/2010) ("UPMC Magee" or "Provider"). The Medicare Contractor ("MAC") issued a Notice of Reopening on April 22, 2016, in which it advised that the cost report was being reopened: "[t]o review your request to recalculate the hospital's SSI percentage based on the fiscal year 06/30/10."[1]

On May 24, 2017, the Medicare Contractor issued the Revised Notice of Program Reimbursement ("RNPR")).[2] Audit Adjustment No. 4 was "[t]o adjust the Allowable DSH percentage to account for CMS' recalculation of the Provider's SSI percentage. ***Ref: 42 CFR 412.106(b)(3)***."[3] Note 42 C.F.R. § 412.106(b)(3) is the regulation allowing hospitals to request realignment of their SSI percentage.

On September 28, 2017, the Provider Reimbursement Review Board (the "Board") received the group appeal request.[4] The group issue states:

[1] Provider's Request for Appeal (Sep. 28, 2017); At the time of this review, there was only a single provider in the group.
[2] *Id*.
[3] *Id*. (emphasis added).
[4] *Id*.

> The issue in this group appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days").[5]

Board's Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2017), 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 (2017), 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)[6] 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.

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[5] *Id.* at Tab 3, Issue Statement.

[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).

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

> (a) *Right to hearing on final contractor determination.* A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).

As described below, the Board finds that it does not have jurisdiction over the Part C Days issue in this appeal for the single participant that filed from a revised NPR because the revised NPR was issued as a result of the Provider's SSI Realignment request, and did not make adjustments related to the Part C days issue.

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

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

> (2) *First computation: Federal fiscal year.* **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -
>
> (i) Determines the number of patient days that -
>
> (A) Are associated with discharges occurring **during each month**; and

[7] 42 C.F.R. § 405.1889(b)(1).

> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[8]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[9] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[10]

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

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will*

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[8] (Emphasis added.)
[9] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[10] (Emphasis added.)

> *make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[11]

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

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the RNPR appeal of the DSH Part C days issue by UPMC Magee. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[12]

Finally, the Board notes that UPMC ***already*** had a CIRP group appeal for the Part C days issue for 2010 under Case Nos. 14-2022GC and 14-2021GC where Ropes & Gray was the designated representative. On May 19, 2017, the Board granted EJR in these two cases and closed them. It is unclear whether UPMC Magee was a participant in Case Nos. 14-2022GC and/or 14-2021GC. Regardless, 42 C.F.R. 405.37(b)(1) specifies that there may be only one CIRP group established by a healthcare chain for a common issue for a particular year. To this end, 42 C.F.R. § 405.1837(e)(1) states: "When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, ***no other provider under common ownership or control may appeal to the Board the issue*** that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal." As UPMC had already fully litigated the Part C issue for 2010 before the Board, UPMC had no right to later establish a duplicate CIRP group under Case No. 17-2285GC.

In conclusion, the Board is dismissing the sole participant from the CIRP group because it does not have the right to appeal the RNPR at issue under 42 C.F.R. § 405.1889 for the DSH Part C days issue. Moreover, the Board has a separate and independent basis to dismiss the CIRP group because 42 C.F.R. § 405.1837(e)(1) expressly prohibits the establishment of this duplicate 2010

[11] (Emphasis added.)
[12] *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).

UPMC CIRP group. As there are no remaining participants in the CIRP group and the CIRP group is a prohibited duplicate CIRP group, the Board hereby closes Case No. 17-2285C 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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Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

For the Board:

9/10/2021

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

Priscilla Gonzalez
Eden Hospice Care, Inc.
333 S Brea Canyon Rd., Ste. 107
Diamond Bar, CA 91765

RE: ***Notice of Dismissal***
Eden Hospice Care, Inc. (Provider No. 75-1575)
FFY 2020
PRRB Case No. 20-0458

Dear Ms. Gonzalez,

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

Pertinent Facts:

On December 6, 2019, Eden Hospice Care, Inc. ("Provider") filed its appeal request, appealing a quality reporting decision which reduced its annual payment FFY 2020. On December 11, 2019, the Board issued an Acknowledgement and Critical Due Dates notification which established a due date of August 2, 2020 for the Provider's Preliminary Position Paper. This notice explicitly stated that "if the Provider misses any of its due dates, the Board will dismiss the appeal." On May 22, 2020, the Board issued a Notice of Hearing which set a hearing date for January 27, 2021.

On January 29, 2021, the Board acknowledged a request to change the Provider's designated representative, and on February 25, 2021 the Board issued a Final Notice of Hearing, which set a new hearing date of August 24, 2021 and specifically exempted the filing deadlines from Alert 19's suspension of Board-set deadlines.[1]

On July 14, 2021, Board staff contacted the Provider's Representative to inquire whether the Provider was pursuing the appeal since it did not file its Final Position Paper. Additionally, on August 31, 2021, the Board issued a Request for Information requiring the Provider to file its Final Position Paper within ten (10) days, and that a failure to do so "**will result** in dismissal of the appeal for abandonment." Thus, the deadline to respond was Friday, September 10, 2021.

[1] *Available at* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts. Alert 19 went into effect on March 25, 2020 in response to the COVID-19 pandemic. Among other things, Alert 19 indefinitely suspended all "Board-Set Deadlines" from Friday, March 13, 2020 forward.

However, the Provider failed to timely respond by this deadline and, to date, the Board has received no response to this request and no filings have been made.

Relevant Law and Analysis:

Board Rule 41.2 (Aug. 29, 2018) permits dismissal or closure of a case on the Board's own motion:

- **if it has a reasonable basis to believe that the issues have been fully settled or abandoned**,
- upon failure of the provider or group to comply with Board procedures,
- **if the Board is unable to contact the provider or representative at the last known address**, or
- upon failure to appear for a scheduled hearing.

The regulations governing position papers can be found at 42 C.F.R. § 405.1853:

> (b) Position papers. (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. In each case, and as appropriate, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board.
> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (as described in §405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.

Failure to comply with the Board's deadline for submission of its Position Paper can be found at 42 C.F.R. § 405.1868:

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

> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.

Similarly, the Board's Rules (August 29, 2018) further emphasize the need for the parties to meet filing deadlines. Rule 23.1 states, in pertinent part:

> To give the parties maximum flexibility and for judicial economy, the parties may choose one of the following prehearing scheduling options:
>
> - Jointly agree to a proposed Joint Scheduling Order (JSO) . . . or,
> - If the parties do not elect the JSO process, file a preliminary position paper and follow the timelines established by the Board in its acknowledgement letter.
>
> **Upon receiving an appeal request, the Board will send an acknowledgement establishing the first filing due date. By that date, the parties must take one of the options.**[2]

Rule 23.3 is accompanied with a heading that reads "Preliminary Position Papers Required if no Proposed JSO is Executed" and explains:

> If the parties do not jointly execute and file a proposed JSO by the due date, the position paper deadlines established in the acknowledgement letter will control. Both parties must file preliminary position papers that comply with Rule 25 (and exchange documentation) by their respective due dates.

Rule 23.4, "Failure to Timely File" further states:

> The Provider's preliminary position paper due date will be set on the same day as the PJSO due date; accordingly, if neither a PJSO nor the provider's preliminary position paper is filed by such date, **the case will be dismissed**.[3] If the Intermediary fails to timely file a responsive preliminary position paper by its due date, the Board will take the actions described under 42 C.F.R. § 405.1868.

Finally, Rule 23.5 related to extension requests for Preliminary Position Papers and the associated commentary states that an extension **must** be filed at least three weeks before the due date and will only be granted for good cause.

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[2] Emphasis in original.
[3] Emphasis added.

Board Decision:

The Board finds that the Provider has failed to comply with the Board's procedures, specifically the filing deadlines set in this case and, further, that it has been unable to contact the provider or representative at the last known address. The Provider has essentially ignored all contacts from the Board whether formal or informal and has had multiple opportunities to comply with the deadline for filing its position paper. As such, the Board hereby deems this case abandoned and, pursuant to its authority under 42 C.F.R. § 405.1868, dismisses the case and removes it from its docket.

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

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For the Board:

9/13/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Board Chair
Signed by: PIV

cc: Wilson C. Leong, Esq., Federal Specialized Services
Edward Lau, Esq., Federal Specialized Services
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Stephanie Webster, Esq.
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Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
Case No. 13-1539GC – Shands HealthCare 2008 DSH Medicare Advantage Days CIRP Group
Case No. 13-2431GC – Shands HealthCare 2008 DSH Medicaid Fraction Medicare Advantage Days CIRP Group
Case No. 18-0948GC – Shands HealthCare 2009 DSH Medicare Advantage Days CIRP Group
Case No. 18-1382GC – Shands HealthCare 2010 DSH Medicare Advantage Days CIRP Group

Dear Ms. Webster:

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

The subject CIRP groups are fully formed.[2] On September 2, 2021, the Providers in the above-referenced CIRP group appeals filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue, asking the Board to grant EJR despite the issuance of CMS Ruling 1739-R, and further challenging said ruling.[3] The Board's decision to bifurcate the Providers' EJR Request, and the grant it in part and deny it in part, is set forth below.

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[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).
[2] The Board notes that, with respect to fully formed or complete CIRP groups, 42 C.F.R. 405.1837(e)(1) states, in pertinent part: "When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, ***no other provider under common ownership or control may appeal to the Board the issue*** that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal." (Emphasis is added.)
[3] Providers' Petition for Expedited Judicial Review (Sep. 2, 2021), PRRB Case no. 13-1539GC; See id. at PRRB Case Nos. 13-2431GC, 18-0948GC, and 18-1382GC.

Statutory and Regulatory Background:

Medicare Advantage Program

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

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

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

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[6]

With the creation of Medicare Part C in 1997,[7] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under

[4] of Health and Human Services.
[5] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[6] *Id.*
[7] 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

Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[8]

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* . . . .[9]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[10] 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.[11]

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.

[8] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[9] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[10] 69 Fed. Reg. at 49099.

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

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[12] 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).[13] 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."[14]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[15] 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.[16] In *Allina Health Services v. Price* ("*Allina II*"),[17] 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*.[18] 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.[19] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[20]

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[12] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[13] *Id*. at 47411.
[14] 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).
[15] 746 F. 3d 1102 (D.C. Cir. 2014).
[16] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[17] 863 F.3d 937 (D.C. Cir. 2017).
[18] *Id*. at 943.
[19] Id. at 943-945.
[20] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[21] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[22] The Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[23]

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

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any

[21] CMS Ruling 1739-R (Aug. 17, 2020).
[22] *Id*.
[23] *Id*.

> subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[24]

<u>Providers' Request for EJR</u>:

The Providers within the CIRP group appeals are challenging their Medicare reimbursement for the fiscal year 2008-10 cost reporting periods. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[25] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[26] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[27] As such, the Providers conclude that the Board is "required" to grant EJR.[28]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[29] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[30]

The Providers also argue that:

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[24] CMS Ruling 1739-R at 6-7.
[25] Providers' Petition for Expedited Judicial Review, at 1 (Sep. 2, 2021), PRRB Case no. 13-1539GC; See id. at PRRB Case Nos. 13-2431GC, 18-0948GC, and 18-1382GC.
[26] *Id*. at 1.
[27] *Id*.
[28] *Id*. at 1-2.
[29] *Id*. at 11-12.
[30] *Id*. at 21.

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here….[31]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz,* 536 U.S. 622, 627 (2002)).[32]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[33]

<u>Board's Analysis and Decision</u>:

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

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, as explained

[31] *Id*. at 13-14.
[32] *Id*. at 14.
[33] *Id*. at 17.

supra. This first issue is the ***substantive issue*** upon which the Providers established the CIRP group and the source of the Providers' dissatisfaction.

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

Board's Authority

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

The Board's analysis is detailed below.

Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[34, 35]

The Providers included in the instant EJR requests filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending from 6/3/2008 through 6/30/2010.

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

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[34] 42 C.F.R. § 405.1835(a).

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

[36] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[37]

On August 21, 2008, new regulations governing the Board were effective.[38] 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*").[39] 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.[40]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R ("CMS 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods that ended on or after December 31, 2008, and began before January 1, 2016, that were pending or filed on or after April 23, 2018.[41] Under this Ruling, if the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) is no longer applicable. However, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.[42]

The Providers included in the instant EJR request filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2009 and are governed by CMS Ruling CMS-1727-R.[43] The Board further finds that the Providers appeals are permitted under the dictates of CMS-1727-R because they self-disallowed their claims based on the regulation at issue and are challenging the validity of that regulation.

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[37] *Bethesda* at 1258-59.
[38] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[39] 201 F. Supp. 3d 131 (D.D.C. 2016).
[40] *Banner* at 142.
[41] CMS Ruling CMS-1727-R at 1-2.
[42] *Id*. at unnumbered page 7.
[43] Under Ruling 1727-R, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

Finally, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000 as required for a group appeal.[44, 45] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount in each case.

Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[46] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[47] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[48] To date, CMS has yet to issue its new final rule.[49]

As the Providers' appeals concern the FY 2008-10 cost reporting periods, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[50] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

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[44] *See* 42 C.F.R. § 405.1837.
[45] Although both 18-0948GC and 18-1382GC were established as CIRP group appeals and are fully formed, they only have a single participant and the Board is electing to treat these fully formed CIRP group cases as individual appeals. The appeals were timely filed and the $10,000 amount in controversy for an individual appeal has been met by both Providers per 42 C.F.R. § 405.1835(a)(2).
[46] (Emphasis added.)
[47] CMS Ruling 1739-R at 1-2.
[48] Id. at 2.
[49] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[50] (Emphasis added.)

Validity of CMS Ruling 1739-R

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

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[51]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[52] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

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

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[51] EJR Request at 17.

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

> challenged as being contrary to law and which the Board has no authority to invalidate.[53]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [54] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[55]

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[56] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

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

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

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

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[53] *See Southwest* at 6-7.
[54] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[55] *See* CMS 1739-R at 8.
[56] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

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

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.

For the Board:

9/13/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson Leong, FSS
Geoff Pike, First Coast Service Options, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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September 14, 2021

Russell Kramer
Director
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150 N Santa Anita Avenue, #570A
Arcadia, CA 91006

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

RE: Dismissal of Group - Failure to Respond to Board Requests
QRS Baylor 2010 Rural Floor BNA Group
PRRB Case Number: 12-0295GC

Dear Mr. Kramer and Mr. Tisdale:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject appeal which has been pending for over 7 years since March 2012. On May 10, 2019 and, again, on November 10, 2020, the Board requested the status of the group as no participants had been added since over 7 years ago in June of 2012. Both times, the Representative was directed to advise the Board as to whether the group was complete or, in the alternative, identify which Providers had not yet received a determination. Both Board letters also advised that failure to submit a timely response would result in dismissal of the appeal. As the case has been active for over 7 years and the representative failed to timely comply the the Board-ordered status reports on two separate occasions (subject to dismissal), the Board must conclude the case has been abandoned. Accordingly, the Board hereby dismisses Case No. 12-0295GC pursuant to its authority under 42 C.F.R. 405.1868..

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FOR THE BOARD:

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Chair

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Dismissal of Duplicate Appeal***
Southwest Consulting Conemaugh Health System 2010 DSH SSI Fraction Part C Days CIRP
Case No. 14-2542GC

Dear Ms. Webster and Mr. Snyder:

The above-referenced common issue related party ("CIRP") group appeal for Conemaugh Health System ("Conemaugh") includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. It has come to the attention of the Provider Reimbursement Review Board ("PRRB" or "Board") that it has already granted Conemaugh EJR for the ***same*** issue under appeal and the ***same*** year. As such, the above CIRP group appeal violates the CIRP regulation, is duplicative, and is dismissed.

Background

The Board received the Group Representative's Request for Hearing dated February 20, 2014, to establish the Conemaugh 2010 DSH SSI Fraction Part C Days CIRP group under Case No. 14-2542GC. The group appeal request contained the following issue statement regarding the appealed Part C Days issue:

> The Providers contend that all of the Medicaid eligible Medicare part C days at issue must be counted in the numerator of the Medicaid fraction and that part C days must be excluded in their entirety from the Medicare Part A/SSI fraction. (vacating CMS's rule requiring part C days to be included in the Medicare Part NSSI fraction because CMS did not provide adequate notice to hospitals regarding the change in interpretation adopted in 2004 and because the Secretary provided an insufficient explanation for the change)....[1]

[1] Providers' Group Appeal Request, at Issue Statement (Feb. 20, 2014).

In its review of the documentation for the remand of these issues pursuant to CMS Ruling 1739-R, the Board discovered that Conemaugh has *already* been granted EJR for the Part C days issue for this specific Fiscal Year in a separate CIRP group case. Case No. 12-0375GC entitled "Conemaugh Health System 2010 DSH Medicare Advantage Days CIRP Group," was part of a group of cases granted EJR under lead case 08-0792GC on July 5, 2018.[2]

EJR in 12-0375GC

On or about June 8, 2012, the group representative filed a CIRP group appeal request on behalf of Conemaugh Health System to establish Case No. 12-0375GC. On April 17, 2018, the group representative advised that Case No. 12-0375GC was fully formed. Shortly thereafter, on June 25, 2018, the group representative in Case No. 12-0375GC requested EJR for the following issue:

> [W]hether Medicare Part C patients are 'entitled to benefits under Part A, such that they should be counted in the Medicare Part A/SSI [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator **or vice-versa**.[3]

On July 5, 2018, the Board granted the Expedited Judicial Review ("EJR") request for Case No. 12-0375GC entitled "Conemaugh Health System 2010 DSH Medicare Advantage Days CIRP Group."[4] Case No. 12-0375GC was for the same parent organization, Conemaugh Health, and the same fiscal year as in Case No. 14-2542GC, the case at issue.

Board's Analysis and Decision

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation:

> Two or more providers *under common ownership or control* that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, ***must** bring* the appeal as a group appeal.[5]

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[2] EJR Determination (Jul 5, 2018), PRRB Case Nos. 08-0792GC, et al.
[3] Expedited Judicial Review Request (Jun. 25, 2018), PRRB Case No. 08-0792GC, *et al.* (emphasis added) (further clarifying in its introduction, "[t]he Hospitals seek expedited judicial review ("EJR") of the rule including Part C days in the DSH Medicare Part A/SSI fraction and excluding Medicaid-eligible Part C days from the numerator of the Medicaid fraction."). NOTE: The EJR request covered multiple cases including Case No. 12-0375GC and Case No. 08-0792GC was the lead case.
[4] EJR Determination (Jul 5, 2018), PRRB Case Nos. 08-0792GC, et al.
[5] 42 C.F.R. § 405.1837(b)(1) (emphasis added).

Subsection (e) requires that the group provider provide notice that the group is fully formed and complete.[6] *Once the group is certified as complete*, restrictions are placed on the ability for additional providers under common ownership:

> When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, *absent an order from the Board modifying its determination*, ***no other provider under common ownership or control may appeal to the Board the issue*** that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.[7]

The concept that commonly owned or controlled providers can only have a single CIRP group per common issue per year is echoed in the following Board Rules:

> **4.6 No Duplicate Filings**
>
> **4.6.1 Same Issue from One Determination**
>
> A provider may *not* appeal an issue from a single final determination *in more than one appeal*.
>
> **4.6.2 Same Issue from Multiple Determinations**
>
> *Appeals of the same issue from distinct determinations must be pursued in a single appeal*. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals.
>
> **4.6.3 Issue Previously Dismissed or Withdrawn**
>
> Once an issue is dismissed or withdrawn, the issue may not be appealed in any other case.
>
> ****
>
> **12.10 Certifications**
>
> The person filing the appeal request on behalf of a group must certify the submission, specifically:
>
> - I certify that the group issue filed in this appeal is *not pending in any other appeal for the same period for the same providers*, *nor has it been adjudicated*, withdrawn, or dismissed from any other PRRB appeal.

[6] 42 C.F.R. § 405.1837(e)(1).
[7] *Id*. (emphasis added).

- I certify to the best of my knowledge that there are *<u>no other providers</u> to which these participating providers are related by common ownership or control* that have a pending request for a Board hearing on the ***same*** issue for a cost reporting period that ends in the ***same*** calendar year covered in this request. See 42 C.F.R. § 405.1837(b)(1)(i). (This certification applies to optional groups only.)
- *I certify that I have read and am familiar with Board* statutes, *regulations, and rules* and, to the best of my knowledge, the appeal is *filed in full compliance* with such statutes, regulations, and rules.
- I am authorized to submit an appeal on behalf of the listed providers.[8]

Based on the above regulations and Board Rules, once an organization's CIRP group for a particular issue and year is fully formed, any additional providers in that organization appealing the same issue and year outside of this CIRP group would be part of a duplicate case, violating the CIRP regulations and Board Rule 4.6.[9] As Case No. 14-2542GC was part of the same common ownership, for the same issue (Part C Days), and for the same year as that in Case No. 12-0375GC, Case No. 14-2542GC and any providers within that CIRP group are in violation of § 405.1837(b)(1) and (e), and thus must be dismissed.

Further, to the extent there are any providers in Case No. 14-2542GC that also participated in Case No. 12-0375GC, those overlapping providers would violate Board Rule 4.6 prohibiting duplicate appeals of the ***same*** issue from the ***same*** year (whether by the same determination (Rule 4.6.1) or by multiple determinations (Rule 4.6.2)). Upon review, there appears to be only one participant in Case No. 14-2542GC which was added to the CIRP group at its formation in 2014 – Memorial Medical Center in Johnstown, PA ("Memorial"). As Case No. 12-0375GC was open when Case No. 14-2542GC was established, the group representative should have added Memorial to Case No. 12-0375GC rather than improperly forming a duplicate CIRP group for the same issue and year with Memorial as the founding participant. Similarly, to the extent Memorial was not also a participant in Case No. 12-0375GC, the group representative erred in certifying on April 17, 2018 that Case No. 12-0375GC was fully formed/complete and instead should have transferred the sole participant from Case No. 14-2542GC to Case No. 12-0375GC.

Finally, the Board notes that the EJR request for which the Board granted EJR in Case No. 12-0375GC (as well as the Board's EJR decision itself) clearly encompassed the ***complete*** Part C DSH issue, *i.e.*, both the Medicare and Medicaid fractions. Per the 2014 holding of the D.C.

[8] (Underline and italics emphasis added.)
[9] *See* 42 C.F.R. § 405.1837(e) ("[w]hen the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.").

Circuit in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"),[10] the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction.[11] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[12] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board dismisses the DSH Part C Days issue from Case No. 14-2542GC because the issue was disposed of when the Board granted the EJR of Case No. 12-0375GC and because Case No. 14-2542GC violated the CIRP regulations 42 C.F.R. § 405.1837(b)(1) and (e), and dismisses the case.

The Board hereby closes the group appeal 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.

<u>Board Members Participating</u>:

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

For the Board:

9/17/2021

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson Leong, FSS

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[10] 746 F.3d 1102, 1108 (D.C. Cir. 2014).

[11] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.

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

Attachment A

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Group Formation Schedule of Providers

Group Name: Southwest Consulting Conemaugh Health System 2010 DSH SSI Fraction Part C Days Group Page No. 1 of 1

Representative: Akin Gump Strauss Hauer & Feld LLP Date Submitted: 2/19/2014

Case No: Not Yet Assigned Issue: Whether Medicare Part C Days were properly treated in CMS's calculation of the SSI Fraction.

Lead Intermediary: Novitas Solutions, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	39-0110	Memorial Medical Center (Johnstown, Cambria, PA)	Novitas Solutions, Inc.	6/30/2010	8/30/2013	2/19/2014^	173	150, 157, 160, 804, 823	$1,156,538	Direct Add	2/19/2014^
								Total Amount of Reimbursement:	$1,156,538		

^ This is the date the appropriate correspondence was sent to the Board by Federal Express Overnight Delivery. The filed date for this correspondence is presumed to be one business day after this date. See PRRB Rule 4.3.

Date Prepared: 2/19/2014

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Decision* – No Right to Appeal & Duplicate CIRP Group**
CHI 2009-2010 Revised NPR DSH Medicare Advantage Part C Days CIRP Group
Case No. 17-2289GC

Dear Messrs. Newell and Snyder:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in the common issue related party ("CIRP") group under Case No. 17-2289GC. The Board's decision is set forth below.

Background

The Provider Reimbursement Review Board (the "Board") received the Providers' Request for Hearing dated September 28, 2017.[1] The appeal included a single issue:

> The issue in this group appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days").[2]

There are currently five (5) participants in this group that have all appealed from revised NPRs that were issued subsequent to their requests for SSI realignment. Specifically:

- St. Vincent Medical Center (PN 04-0077, 6/30/2010)
  - Adj. No 4: "To realign the Hospital SSI percentage to the cost reporting period, and to update the allowable [DSH] percentage to account for the change in the SSI."
- CHI Health Mercy Council Bluffs (PN 16-0028, 6/30/2009)
  - Adj. No. 6: "To adjust the hospital DSH payment percentage on Worksheet E, Part A, Line 4.03, Column 1 based on the hospital's Realignment SSI percentage as calculated by CMS."

[1] Providers' Request for Appeal (September 28, 2017).
[2] *Id*. at Tab 3, Issue Statement.

- Mercy Medical Center Des Moines (PN 16-0083, 6/30/2009)
  - Adj. No. 5: "To adjust the cost report to include the hospital's Realignment SSI percentage as calculated by CMS."
- CHI Health Good Samaritan (PN 28-0009, FYE 6/30/2009)
  - 11/13/2014 Notice of Reopening: "We received your requests for recalculations of the Hospitals' Supplemental Security Income/Medicare Part A percentage. We forwarded the requests to [CMS]. When we receive a response from CMS, we will recalculate the hospital's disproportionate share adjustment, if necessary."
- CHI Health Bergen Mercy (PN 28-0060, 6/30/2009)
  - 10/13/204 Provider's Request for Realignment, "[Provider] requests a recalculation of the SSI percentage based on its own fiscal year dating 7/1/2008 – 6/30/2009."

Board's Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2017), 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 ($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 revised NPR at 42 C.F.R. § 405.1885 (2017), 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 (2017)[3] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

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

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

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

> (a) *Right to hearing on final contractor determination.* A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[4]

As described below, the Board finds that it does not have jurisdiction over the Part C Days issue in this appeal for all of the participants that filed from revised NPRs, because the revised NPRs were issued as a result of the Providers' SSI Realignment request, and did not make adjustments related to the Part C days issue.

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 percentages from the federal fiscal year end to their individual cost reporting fiscal year end. The audit adjustments associated with the revised NPRs under appeal clearly revised the SSI percentage in order to realign it from a federal fiscal year to the providers' respective fiscal year. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage.

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

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

> (2) *First computation: Federal fiscal year.* **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -
>
> (i) Determines the number of patient days that -
>
> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[7] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[8]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or*

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

> *not it is a more favorable number than the DSH percentage based on the Federal fiscal year. . . .*
>
> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the **months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[9]

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

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the RNPR appeal of the DSH Part C days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[10]

Finally, the Board notes that CHI ***already*** had CIRP group appeals for the Part C Days issue for 2009 under Case Nos. 13-0876GC and 13-0877GC, and for 2010 in 13-1187GC, where Ropes & Gray was the designated representative. On August 28, 2017, the Board granted EJR in these three cases and closed them. It is unclear whether these 5 participants were participants in 13-0876GC, 13-0877GC, or 13-1187GC. Regardless, 42 C.F.R. § 405.1837(b)(1) specifies that there may be only one CIRP group established by a healthcare chain for a common issue for a particular year. To this end, 42 C.F.R. § 405.1837(e)(1) states: "When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, ***no other provider under common ownership or control may appeal to the Board the issue*** that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal." As

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[9] (Emphasis added.)

[10] *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).

CHI had already fully litigated the Part C issue for 2009 and 2010 before the Board, CHI had no right to later establish a duplicate CIRP group under Case No. 17-2289GC.

In conclusion, the Board is dismissing all of the participants from this CIRP group because they do not have the right to appeal the revised NPRs at issue under 42 C.F.R. § 405.1889 for the DSH Part C days issue. Moreover, the Board has a separate and independent basis to dismiss the CIRP group because 42 C.F.R. 405.1837(e)(1) expressly prohibits the establishment of this duplicate 2009 – 2010 CHI CIRP Group. As there are no remaining participants in the CIRP group, and the CIRP group is a prohibited duplicate CIRP group, the Board hereby closes Case No. 17-2295C 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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Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

For the Board:

9/17/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

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RE: *Jurisdictional Decision* – No Right to Appeal & Duplicate CIRP Group
Southwest Consulting Memorial Hermann 2008 Revised NPR Part C Days CIRP Group
Case No. 17-2290GC

Dear Messrs. Newell and Tisdale:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in the common issue related party ("CIRP") group under Case No. 17-2290GC. The Board's decision is set forth below.

Background

There is only one participant in this group appeal, Memorial Hermann Northeast (PN 45-0684, 12/31/2008). The Medicare Contractor issued a Notice of Reopening on March 8, 2017, in which it advised that the cost report was being reopened: "To update the SSI percentage and DSH payment percentage per Provider's request to recalculate the SSI percentage using their cost report Fiscal Year."[1]

On May 19, 2017, the Medicare Contractor issued the Notice of Amount of Corrected Program Reimbursement ("Revised NPR").[2] Audit Adjustment 4 was "To update provider's SSI percentage per CMS release."

The Board received the Request for Hearing on September 28, 2017.[3] The appeal included a single issue:

> The issue in this group appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days").[4]

[1] Provider's Request for Appeal (Sept. 28, 2017). At the time of this review, there was only a single provider in the group.
[2] *Id*.
[3] *Id*.
[4] *Id*. at Tab 3, Issue Statement.

Board's Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2017), 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 ($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 (2017), 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 (2017)[5] explains the effect of a cost report revision:

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

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

> (a) *Right to hearing on final contractor determination.* A provider . . . has a right to a Board hearing, as a single provider appeal,

[5] *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).

> with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[6]

As described below, the Board finds that it does not have jurisdiction over the Part C Days issue in this appeal for the sole participant that filed from a revised NPR because the revised NPR was issued as a result of the Provider's SSI Realignment request, and did not make adjustments related to the Part C days issue.

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[.]"[7] The reopenings in this case were a result of the Providers' request to realign their SSI percentages from the federal fiscal year end to their individual cost reporting fiscal year end. The audit adjustments associated with the revised NPRs under appeal clearly revised the SSI percentage in order to realign it from a federal fiscal year to the providers' respective fiscal year. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage.

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

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

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[6] (Emphasis added.)
[7] 42 C.F.R. § 405.1889(b)(1).

(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[8]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[9] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[10]

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

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

[8] (Emphasis added.)
[9] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[10] (Emphasis added.)

> *fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[11]

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

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the revised NPR appeal of the DSH Part C days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[12]

Finally, the Board notes that Memorial Hermann ***already*** had a CIRP group appeal for the Part C Days issue for 2008 under Case No. 13-0736GC, where Ropes & Gray was the designated representative. On May 19, 2017, the Board granted EJR and closed the appeal. It is unclear whether Memorial Hermann Northeast was a participant in 13-0736GC. Regardless, 42 C.F.R. § 405.1837(b)(1) specifies that there may be only one CIRP group established by a healthcare chain for a common issue for a particular year. To this end, 42 C.F.R. § 405.1837(e)(1) states: "When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, ***no other provider under common ownership or control may appeal to the Board the issue*** that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal." As Memorial Hermann had already fully litigated the Part C issue for 2008 before the Board, CHI had no right to later establish a duplicate CIRP group under Case No. 17-2290GC.

In conclusion, the Board is dismissing the sole participant from this CIRP group because it does not have the right to appeal the revised NPR at issue under 42 C.F.R. § 405.1889 for the DSH Part C days issue. Moreover, the Board has a separate and independent basis to dismiss the CIRP group because 42 C.F.R. § 405.1837(e)(1) expressly prohibits the establishment of this duplicate 2008 Memorial Hermann CIRP Group. As there are no remaining participants in the CIRP group, and the CIRP group is a prohibited duplicate CIRP group, the Board hereby closes Case No. 17-2290GC and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[11] (Emphasis added.)

[12] *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).

Board Members Participating:

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

For the Board:

9/17/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision* – No Right to Appeal & Duplicate CIRP Group**
Southwest Consulting Memorial Hermann 2010 Revised NPR Part C Days CIRP Group
FYE: 12/31/2010
Case No.: 17-2291GC

Dear Messrs. Newell and Tisdale:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in the common issue related party ("CIRP") group under Case No. 17-2291GC. The Board's decision is set forth below.

Background

There is only one participant in this group appeal, Memorial Hermann Northeast (PN 45-0684, 12/31/2010). The Medicare Contractor issued a Notice of Reopening on April 24, 2017, in which it advised that the cost report was being reopened: "To update the SSI percentage and DSH payment percentage per Provider's request to recalculate the SSI percentage using their cost report Fiscal Year."[1]

On May 19, 2017, the Medicare Contractor issued the Notice of Amount of Corrected Program Reimbursement ("Revised NPR").[2] Audit Adjustment 4 was "To update provider's SSI percentage per CMS release." The appeal included a single issue:

> The issue in this group appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days").[3]

---

[1] Provider's Request for Appeal (Mar. 8, 2017); At the time of this review, there was only a single provider in the group.
[2] *Id*.
[3] *Id*. at Tab 3, Issue Statement.

Board's Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2017), 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 ($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 (2017), 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 (2017)[4] explains the effect of a cost report revision:

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

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

> (a) *Right to hearing on final contractor determination.* A provider . . . has a right to a Board hearing, as a single provider appeal,

[4] *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).

> with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[5]

As described below, the Board finds that it does not have jurisdiction over the Part C Days issue in this appeal for the sole participant that filed from a revised NPR because the revised NPR was issued as a result of the Provider's SSI Realignment request, and did not make adjustments related to the Part C days issue.

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[.]"[6] The reopenings in this case were a result of the Providers' request to realign their SSI percentages from the federal fiscal year end to their individual cost reporting fiscal year end. The audit adjustments associated with the revised NPRs under appeal clearly revised the SSI percentage in order to realign it from a federal fiscal year to the providers' respective fiscal year. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage.

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

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

[5] (Emphasis added.)
[6] 42 C.F.R. § 405.1889(b)(1).

> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[7]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[8] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[9]

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

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

[7] (Emphasis added.)
[8] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[9] (Emphasis added.)

> *fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[10]

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

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the revised NPR appeal of the DSH Part C days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[11]

Finally, the Board notes that Memorial Hermann ***already*** had CIRP group appeals for the Part C Days issue for 2010 under Case Nos. 14-3970GC and 14-3966GC, where Ropes & Gray was the designated representative. On April 12, 2017, the Board granted EJR in these two cases and closed them. It is unclear whether Memorial Hermann Northeast was a participant in 14-3970GC and/or 14-3966GC. Regardless, 42 C.F.R. § 405.1837(b)(1) specifies that there may be only one CIRP group established by a healthcare chain for a common issue for a particular year. To this end, 42 C.F.R. § 405.1837(e)(1) states: "When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, ***no other provider under common ownership or control may appeal to the Board the issue*** that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal." As Memorial Hermann had already fully litigated the Part C issue for 2010 before the Board, CHI had no right to later establish a duplicate CIRP group under Case No. 17-2291GC.

In conclusion, the Board is dismissing the sole participant from this CIRP group because it does not have the right to appeal the revised NPR at issue under 42 C.F.R. § 405.1889 for the DSH Part C days issue. Moreover, the Board has a separate and independent basis to dismiss the CIRP group because 42 C.F.R. § 405.1837(e)(1) expressly prohibits the establishment of this duplicate 2008 Memorial Hermann CIRP Group. As there are no remaining participants in the CIRP group, and the CIRP group is a prohibited duplicate CIRP group, the Board hereby closes Case No. 17-2291GC and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[10] (Emphasis added.)

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

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For the Board:

9/17/2021

X Clayton J. Nix

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Chair
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cc: Wilson Leong, Federal Specialized Services

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RE: ***Jurisdictional Decision***
Camden-Clarke Memorial Hospital (Prov. No. 51-0058)
FYE 12/31/2015
Case No. 20-0477

Dear Ms. Repine and Ms. Johnson,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI – Provider Specific issue because it is the same as the DSH/SSI - Systemic Errors issue that was transferred to PRRB Case No. 20-0064GC, WVU Medicine CY 2015 DSH SSI Percentage CIRP Group. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On November 19, 2019, the Board received Provider's Individual Appeal Request appealing their May 22, 2019 Notice of Program Reimbursement ("NPR") for fiscal year ending December 31, 2015. The initial appeal contained the following three (3) issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH SSI Percentage[1]
3. Standard Payment Amount[2]

The Provider is part of the West Virginia University Health System ("WVU Health") and, as such, is subject to mandatory requirements for the common issue related party ("CIRP") groups. To this end, on June 18, 2020, the Provider transferred Issues 2 and 3 to the WVU Health CIRP groups under Case Nos. 20-0064GC and 20-0065GC, respectively. Accordingly, the ***only*** remaining issues in this appeal is Issue 1 (the DSH/SSI Percentage (Provider Specific) issue).

In its Appeal Request, the Provider summarizes Issue 1, the DSH/SSI – Provider Specific issue, as follows:

---

[1] Issue 2 was transferred to PRRB Group Case No. 20-0064GC on June 18, 2020.
[2] Issue 3 was transferred to PRRB Group Case No. 20-0065GC on June 18, 2020.

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i)of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider *is seeking SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. See 42 U.S.C. § 1395(d)(5)(F)(i).
>
> 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 refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[3]

In its individual appeal request, the Provider describes Issue 2 as follows:

> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their
> DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww

[3] Individual Appeal Request, Issue 1 (emphasis added).

> (d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> 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 refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. *Availability of MEDPAR and SSA Records*
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. *Not in agreement with provider's records*
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days[4]

The Provider transferred Issue 2 to the WVU Health CIRP group for DSH/SSI Systemic Errors in Case No. 20-0064GC.

On October 15, 2020, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor which argued that the Board lacks jurisdiction over the DSH/SSI Provider Specific issue because it is duplicative of the issue which was transferred to case 20-0064GC. It also argues that the decision to realign a hospital's SSI percentage with its fiscal year end is a

[4] *Id*. at Issue 2 (emphasis added).

hospital election, not an appealable Medicare Contractor determination, and since the Provider did not request an SSI realignment, appealing this issue is premature since there was no final determination.[5]

The Provider did ***not*** file a response to the Medicare Contractor's jurisdictional challenge. Per Board Rule 44.4.3, "[f]ailure [of the provider] to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Decision:

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

The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

A. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue that was transferred to Group Case No. 20-0064GC.

The Board finds that the first aspect of Issue 1 (the DSH SSI Percentage (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH SSI Percentage (Systemic Errors) issue) that was transferred to Case No. 20-0064GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[6] The Provider's legal basis for its DSH/SSI (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[7] Similarly, the Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . specifically disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[8]

---

[5] Medicare Administrative Contractor's Jurisdictional Challenge at 2 (Oct. 15, 2020).
[6] Individual Appeal Request, Issue 1.
[7] *Id.*
[8] *Id.*

The Provider's Issue 2 which was transferred to the group under Case No. 20-0064GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106. Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 2 in Case No. 20-0064GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 20-0064GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[9] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal (as opposed to transferring it to a CIRP group). In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0064GC. Based on the record before it, the Board is unable to distinguish Issue 1 from Issue 2.[10]

Accordingly, the Board must find that Issues 1 and 2 are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH SSI Percentage (Provider Specific) issue. In the alternative, the Board would dismisses Issue 1 due to the Provider's failure to properly brief the issue in its Final Position Paper in compliance with Board Rules.

B. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing

[9] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[10] Per Board Rule 44.4.3, "Failure [of the Provider] to respond will result in the Board making a jurisdictional determination with the information contained in the record." Here the Provider failed to respond suggesting that it has conceded that the issues are the same.

purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment.

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In summary, as all other issues have been transferred or withdrawn, Issue 1 is the sole remaining issue in this case and the Board hereby dismisses Issue 1 in its entirety. Accordingly, as Issue 1 was the last issue remaining in the appeal, the Board hereby closes the case and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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For the Board:

9/17/2021

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RE: ***Jurisdictional Challenge – DSH SSI Provider Specific***
Lovelace Medical Center (Prov. No. 32-0009)
FYE 2/28/2013
Case No. 15-1415

Dear Messrs. Ravindran and Tisdale:

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

Pertinent Facts:

On February 11, 2015, the Board received Provider's Individual Appeal Request appealing their August 13, 2015 Notice of Program Reimbursement ("NPR") for fiscal year ending February 28, 2013. The initial appeal contained eight (8) issues:

- Issue 1: DSH SSI- Provider Specific
- Issue 2: DSH SSI- Systemic Errors[1]
- Issue 3: DSH SSI- Medicare Managed Care Part C Days[2]
- Issue 3: DSH SSI Fraction/Dual Eligible Days[3]
- Issue 5: DSH Medicaid Eligible Days[4]
- Issue 6: DSH Medicaid Fraction Part C Days[5]
- Issue 7: DSH Medicaid Fraction/Dual Eligible Days[6]
- Issue 8: Outliers[7]

The Provider is part of Ardent Health and, as such, is subject to the mandatory participation in common issue related party ("CIRP") groups. To this end, the Provider transferred Issues 2-4

[1] Issue 2 was transferred to PRRB Case No. 15-3475GC.
[2] Issue 3 was transferred to PRRB Case No. 15-3476GC.
[3] Issue 4 was transferred to PRRB Case No. 15-3478GC.
[4] Issue 5 was withdrawn in a letter dated January 19, 2018.
[5] Issue 6 was transferred to PRRB Case No. 15-3477GC.
[6] Issue 7 was transferred to PRRB Case No. 15-3479GC.
[7] Issue 8 was transferred to PRRB Case No. 15-3480GC.

and 6-8 to CIRP group appeals. The Provider also withdrew Issue 5. Accordingly, based on these transfers and withdrawal, the ***sole*** remaining issue in this appeal is Issue 1. The issue addressed in this decision is Issue 1, the DSH SSI- Provider Specific issue.

In its appeal request, the Provider summarizes Issue 1, the DSH SSI- Provider Specific issue, as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[8]

The DSH SSI- Systemic Errors (Issue 2) issue has been transferred to Case No. 19-3475GC. Similar to Issue 1, Issue 2 "contend[s] that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I)."

The Provider described Issue 2, the DSH SSI- Systemic Errors issue, which has been transferred to Case Number 19-3475GC, as "[w]hether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage." More specifically, the Provider contends that the SSI percentages were not calculated in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(i) and that the SSI percentage "calculated by [CMS] and used by the Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute." The Provider lists the following reasons for challenging its SSI percentage:

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[8] Individual Appeal Request, Issue 1.

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[9]

On September 29, 2015, the Provider filed its preliminary position paper. As this case is a 2015 case, only the first page of the position paper was filed, and therefore the entire paper not available for Board review.

Medicare Contractor's Jurisdictional Challenge

On June 7, 2018, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor which argued that the Board lacks jurisdiction over Issue 1 (the DSH SSI- Provider Specific issue) because it is duplicative of Issue 2, which was transferred to Case No. 19-3475GC.

Provider's Response to the Jurisdictional Challenge

On July 2, 2018, the Provider responded to the Medicare Contractor's jurisdictional challenge and asserted that the Board has jurisdiction over Issue 1 in its entirety – both the provider specific and the realignment sub-issues.

The Provider asserts that the Medicare Contractor is wrong in its assertion that Issue 1 is the same as Issue 2. The Provider notes that Issue 2 pertains to "the various errors discussed in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) in CMS' calculation of the disproportionate payment percentage, which result in the MedPAR not reflecting all individuals who are eligible for SSI . . . These systemic errors are the results [*sic*] of CMS's improper policies and data matching process. The SSI Systemic Issue also covers CMS Ruling 1498-R." In contrast, the Provider asserts that Issue 1 "is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the 'systemic errors' category." In support of its assertion, the Provider asserts that "[i]n *Baystate*, the Board also considered whether, independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio."[10]

Further, the Provider maintains that "it has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI" and that "it has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio." To this end, the Provider asserts that it "has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but

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[9] Individual Appeal Request, Issue 2.
[10] Citing to *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

in any case, are not systemic errors that have been previously identified in the *Baystate* litigation." Notwithstanding, the Provider appears to backtrack by stating that "*[o]nce these patients are identified*, QRS contends that the Provider will be entitled to a correct of these errors of omission to its SSI percentage." In support of this position, the Provider cites to *Northeast Hospital Corporation v. Sebelius* (D.C. Cir. September 13, 2011) wherein CMS specifically abandoned the CMS Administrator's December 1, 2008 decision that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS.[11]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. In this case, the amount in controversy is $39,000 and meets this requirement.

The Board finds that it does not have jurisdiction over Issue 1, the DSH SSI- Provider Specific issue. The jurisdictional analysis of Issue 1 has two components:

1. The Provider's disagreement with the Medicare Contractor's calculation of the SSI percentage used to determine the DSH percentage, and
2. The Provider's preservation of its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

A. First Aspect of Issue 2

The Board finds that the first aspect of Issue No. 1—the Provider's disagreement with the Medicare Contractor's calculation of the SSI percentage used to determine the DSH percentage—is duplicative of the DSH- SSI Percentage issue that was transferred to Group Case No. 19-3475GC.

The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[12] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] Similarly, the Provider argues that "its SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[14] Issue 2, transferred to the group under Case No. 19-3475GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH

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11 *Id.*
[12] Individual Appeal Request, Issue 1.
[13] *Id.*
[14] *Id.*

payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Thus, the Board has determined that the first aspect of Issue 1 in this appeal is duplicative of Issue 2, transferred to Case No. 19-3475GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2013), the Board dismisses this aspect of the DSH SSI- Provider Specific issue.

The Board further notes that the Provider's response to the Medicare Contractor's jurisdictional challenge was filed in July 2018, almost 3 years since it filed its preliminary position paper on September 29, 2015. Under the Board Rules then in effect, the Board only received a copy of the cover page to the Provider's preliminary position paper and is unable to review it. Notwithstanding, at the point in time it filed it response to the jurisdictional challenge, the Board would expect that, *based on the content requirements for preliminary position papers*, that the Provider would be able to succinctly explain the difference between Issue 1 and 2 and give examples. In this regard, the Board notes that it "expects preliminary position papers to be ***fully developed*** and include ***all*** available documentation necessary to give the parties a ***thorough*** *understanding* of their opponent's position."[15] However, the Provider's response to the jurisdiction challenge failed to provide any example or support for its broad brush stroke assertions and allegations. For example, the Provider merely asserts that it "has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not systemic errors that have been previously identified in the *Baystate* litigation." However, the Provider does not explain the basis for its conclusion that these alleged "errors" (for which it provides no concrete examples or exhibits) "are not systemic errors that have been previously identified in the *Baystate* litigation."

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, as this provider is part of a chain, the Provider would be required by the CIRP regulations to pursue that challenge with related providers in a CIRP group appeal and, to that end, is pursuing that issue in Case No. 19-3475GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[16] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-3475GC.

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[15] Board Rule 23.3, Commentary (July 1, 2015) (emphasis added). Similarly, the Commentary to Board Rule 25 (July 1, 2015) states: "preliminary position papers are now expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline." *See also* Board Rules 25.1(A), 25.2.
[16] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). Similarly, there multiple types of systemic issues considered in *Baystate*: "The Board also considered whether, independent of these systemic omissions from the SSI eligibility data, Baystate's SSI fractions were understated due to flaws *in the match **process***." 548 F. Supp. at 28. Alleged flaws in the match process are inherently systemic.

Accordingly, the Board finds that Issues 1 and 2, which was transferred to Group Case No. 19-3475GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH SSI- Provider Specific issue.

B. Second Aspect of Issue 2

The Board finds that the second aspect of the DSH SSI- Provider Specific issue involves the Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." The Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. Accordingly, the second aspect of Issue 1 is exhausted and the Board dismisses it from the appeal.

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In conclusion, the Board hereby dismisses Issue 1 in its entirety as being duplicative, in part, and premature, in part. As no issues remain, the Board hereby closes Case No. 15-1415 and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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FOR THE BOARD:

9/17/2021

Clayton J. Nix, Esq.
Chair
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Determination***
Hall Render CY 2012 DSH SSI Fraction Dual Eligible Days V Group
Case No. 19-0622G

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above Providers' request for expedited judicial review ("EJR Request") received March 4, 2020[1] regarding the above-referenced case, in addition to the June 29, 2020 and December 1, 2020 responses to the Board's April 2, 2020 and October 2, 2020 development letters. The Board's determination regarding the EJR request is set forth below.

Effect of COVID -19 on Board Operations

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On April 15, 2020, subsequent to the submission of the EJR request, the Board notified you of the Issue in relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); *see also* 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned group appeals.

Issue for which EJR is Requested:

The Providers, in the above-referenced group and individual appeals are requesting EJR for the following issue:

[1] The Provider's March 4, 2020 EJR request covered six appeals. The Board's EJR decision for the five other appeals were previously issued.

> The days at issue in these appeals are days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in these appeals is whether the Providers' Medicare DSH reimbursement calculations were understated due to the Centers for the Medicare an Medicaid Services' and the Medicare Adminstratve Contractors failure to include all patient days for patients who were enrolled in and eligible for the SSI program but did not receive an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible days"), in the numberator of the Medicare fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."
>
> The Providers respectfully assert that under the rules of statutory construction CMS is *compelled to interpret "entitlement to SSI" benefits to include all inpatients who were eligible for and/or enrolled in the SSI program at the time of their hospitalization* ***and***, further, to *furnish Providers with a listing of those SSI Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare Act*. Furthermore, Providers seek a ruling that CMS has failed to provide the them with adequate information to allow them to check and challenge CMS'[] disproportionate patient percentage ("DPP") calculations. The Providers are entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173. . . . Because the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of the hospital's Medicare patients who are enrolled in SSI and/or eligible for SSI benefits along with their corresponding SSI status codes, and does not give the Providers any meaningful means of challenging the SSI days chosen by CMS to be used in Provider's DPP calculations, CMS continually violates its § 951 mandate . . . .[2]

Medicare Disproportionate Share Hospital (DSH) Payment Background:

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[3] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income

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[2] EJR Request at 2-3 (emphasis added).
[3] 42 C.F.R. Part 412.

patients. [4] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[5] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

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

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[7] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[8] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or

[4] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[5] (Emphasis added.)
[6] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[7] 42 U.S.C. § 1382.
[8] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).

disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[9]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[10] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[11]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[12] and may terminate,[13] suspend[14] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[15] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[16]
2. The individual fails to apply for other benefits to which the individual may be entitled;[17]
3. The individual fails to participate in drug or alcohol addiction treatment;[18]
4. The individuals is absent from the United States for more than 30 days;[19] or
5. The individual becomes a resident of a public institutions or prison.[20]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[21]

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[9] 20 C.F.R. § 416.202.
[10] 42 U.S.C. § 426.
[11] 42 U.S.C. § 426-1.
[12] 20 C.F.R. § 416.204.
[13] 20 C.F.R. §§ 416.1331-1335.
[14] 20 C.F.R. §§ 416.1320-1330.
[15] 20 C.F.R. § 1320.
[16] 20 C.F.R. § 416.207.
[17] 20 C.F.R. § 416.210.
[18] 20 C.F.R. § 416.214.
[19] 20 C.F.R. § 416.215.
[20] 20 C.F.R. § 416.211.
[21] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[22] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[23] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[24] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[25] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[26]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[27]

[22] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[23] *Id.*
[24] *Id.*
[25] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[26] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[27] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[28] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[29] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[30]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[31] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[32]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[33] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[34] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[35] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe

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[28] CMS-1498-R at 5.
[29] *Id.*
[30] *Id.* at 5-6.
[31] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[32] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[33] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[34] *Id.* at 50280.
[35] *Id.* at 50280-50281.

an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[36] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[37]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[38] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[39] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[40]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[41]

As a result of the Rulings, new regulation, and new data match process, CMS calculated SSI percentages for the Providers for all of fiscal years at issue in this CIRP group appeal.[42] The Providers have appealed original NPRs a based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

<u>Providers' Request for EJR</u>:

The Providers assert that, under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift

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[36] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[37] *Id.* at 50285.
[38] CMS-1498-R at 6-7, 31.
[39] *Id.* at 28, 31.
[40] 75 Fed. Reg. at 24006.
[41] CMS-1498-R2 at 2, 6.
[42] CMS published the SSI ratios for FY 2012 on or about June 12, 2014. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration ("SSA") for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[43]

The Providers note that, in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the FY 2011 IPPS Final Rule that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[44] Thus, the Providers allege the exclusion of the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the DSH statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' disproportionate patient percentage ("DPP") calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA").[45]

Decision of the Board:

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

A. Jurisdiction

The participants that comprise the group appeals within this EJR determination, have filed appeals involving fiscal years 2012.

[43] 75 Fed. Reg. at 50275-86.
[44] *Id.* at 50281.
[45] Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[46] 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.[47]

On August 21, 2008, new regulations governing the Board were effective.[48] 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*").[49] 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.[50]

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

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[46] 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.).
[47] *Bethesda*, 108 S. Ct. at 1258-59.
[48] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[49] 201 F. Supp. 3d 131 (D.D.C. 2016).
[50] *Id.* at 142.

(1) Particpant #6 "Mayo Clinic – LaCrosse" (Prov. No. 52-0004, FYE 12/31/12)

On April 2, 2020, the Board sent the Group Representative correspondence citing 42 C.F.R. § 405.1837(b), which requires commonly owned providers appealing the same issue to establish a group appeal for providers under common ownership. The Board noted that:

1. Participant #6 which is identified on the Schedule of Providers as "the Mayo Clinic-LaCrosse" appears to be owned by the Mayo Clinic Health System-Fransciscan Healthcare; and

2. The Board regulation, 42 C.F.R. § 405.1837(b)(1)(i) governing the mandatory use of group appeals (referred to as "common issue related party" or "CIRP" groups), may be applicable.

Accordingly, the Board asked the Group Representative to determine if there were any other hospitals from the Mayo Clinic Health System-Franciscan Healthcare which have appealed or could appeal the dual eligible days issue for 2012.

On June 29, 2020, the Group Representative filed its response and suggested that the Mayo Clinic-LaCrosse ***is*** related to the Mayo Clinic-Eau Claire (Prov. No. 52-0070) but that a CIRP group was not formed because the Mayo Clinic-Eau Claire had already fully adjudicated its claim before the Board as part of a 2012 ***optional*** group:

> Mayo Clinic – Eau Claire, Provider No. 52-0070, was added to PRRB Case No. 15-2644**G**, the Hall Render 2012 DSH SSI Fraction Dual Eligible Days Group II, on 3/9/16. (Exhibit P-1). Further, PRRB Case No. 15-2644G was granted Expedited Judicial Review by the PRRB on 6/1/18 and the Board subsequently dismissed the case. (Exhibit P-2). *Therefore, this issue was* ***no longer pending before the PRRB*** *for Mayo Clinic – Eau Claire*, Provider No. 52-0070 *when Mayo Clinic Health System – Franciscan Healthcare La Crosse*, Provider No. 52-0004, *was added to PRRB Case No. 19-0622G on 12/12/19*. (Exhibit P-3).[51]

As an additional point, the Group Represenative stated that "[i]t is important to note that during fiscal year ending 12/31/2012, May Clinic Health System – Franciscan Healthcare LaCrosse was a dual sponsorship between Mayo Clinic Health System and Franciscan Healthcare, ***which did not change until October 2018*** when the Franciscan Sisters of Perpetual Adoration ***relased*** their sponsorship. *See* https://www.mayoclinichealthsystem.org/locations/la-cross/about-us/history."[52] Finally, the Group Representative confirmed that they had reviewed the other participants in the optional group and found no related parties for any of these other participating providers that have or may pursue the group's issue for 2012.

[51] (Empahsis added.)
[52] (Empahsis added.)

Subsequently, on October 2, 2020, the Board sent the Group Representative a second development letter advising that June 29th response was insufficient for the Board to determine whether the Mayo Clinic-LaCrosse should be a participant in Case No. 19-0622G. The Board once again, explained that this facility appeared to be owned by a corporate entity, Mayo Clinic Health System-Franciscan Healthcare and noted that 42 C.F.R. § 405.1837(b)(1)(i) may mandate the use of a CIRP group appeal for issue in dispute. The Board noted that the Group Representative had stated that Mayo Clinic-Eau Claire (Prov. No. 52-0070) was a participant in the 2012 ***optional*** group under Case No. 15-2644G which was no longer pending because the Board had granted EJR on June 1, 2018. This suggested to the Board that two different Mayo Clinic Health System hospitals for FYE 2012 have been included in two different ***optional*** group appeals, as opposed to a CIRP group. The Board pointed out that the statute, 42 U.S.C. § 1395oo(f)(1), requires that providers under common ownership or control must file a group appeal with respect to any matter involving an issue common to the providers. The regulation, 42 C.F.R. § 405.1837(b)(1), requires that all commonly owned providers form a group appeal for a common issue for a calendar year. The regulation recognizes that it may be a period of time before a CIRP group is complete and, to avoid premature Board action with respect to a CIRP group, the Group Representative must certify that a group is fully formed.

As a result of Hall Render's failure to include all potential Mayo Clinic hospitals with a common issue for 2012 in the SSI Dual Eligible Days issue group, the Board ordered Hall Render to review all of its optional group appeals of the SSI Dual Eligible Days issue to identify all Mayo Clinic hospitals for 2012 to determine if there are other hospitals that should be included in a CIRP appeal of the issue or awaiting the issuance of an NPR. In issuing this order, the Board stated: "[i]t would appear that Mayo Clinic-Eau Clair and May Clinic-LaCross Hospital are related parties that should have been included in a CIRP group for 2012" and, in support, took administrative notice in the footnote thereto that "both May[o *sic*] Clinic-LaCrosse and May[o *sic*] Clinic-Eau Claire are participants in the May[o *sic*] Clinic ***2013 <u>CIRP</u>*** under Case No. 17-0369GC."[53] The Board also asked the Group Rep to explain the relevance of the Mayo Clinic Health System-Franciscan Healthcare dual sponsorship being in existence from 2012 to 2018 is relevant to the mandatory requirement that commonly owned or controlled providers must for CIRP groups for any common issue occurring in a year.

On December 1, 2020, the Group Representative responded, stating that, for the FY 2012 DSH SSI Fraction Dual Eligible Days group, there were no other Mayo Clinic Health System providers in any of Hall Render's independent groups beyond Mayo Clinic-Eau Claire (Prov. No. 52-0070) which participated in Case No. 15-2644G (for which the Board granted EJR) and Mayo Clinic-LaCrosse (Prov. No. 52-004) which is in the current case, Case No. 19-0622G. Further, the Group Representative included a schedule of the hospitals and their NPR dates to confirm that there are no other hospitals in the system that can appeal the SSI Dual Eligible Days issue for 2012.

[53] (Empahsis added.)

With respect to the relevant of the Mayo Health Clinic System-Franciscan Healthcare, Inc., the Group Representative asserts that this entity is not "a related party" to the Mayo Clinic Health System and, therefore, does not meet the CIRP rule requirements:

> The relevance is that since Mayo Clinic Health System-Franciscan Healthcare (MCHS-FH) was a dual sponsorship between the Mayo Clinic Health System and Franciscan Healthcare, Inc., it was **not** *a related party* to Mayo Clinic Health System (MCHS) and did *not meet* the PRRB's CIRP rule requirements for having to file as a CIRP with other MCHS hospitals whose sole member or "owner" is MCHS.[54]

The Group Representative asserts that, during FY 2012, the Mayo Clinic Health System—Franciscan Healthcare, Inc. had two members that "equally controlled and owned" Mayo Health Clinic System—Franciscan Healthcare, Inc. In support, the Group Representative included as Exhibit P-3 a copy of the corporate bylaws for the Mayo Clinic Health System—Franciscan Healthcare, Inc. and asserts that this document:

1. Shows 2 classes of Members, one class elected by the Congregation of Sisters of the Third Order of Saint Francis of Perpetual Adoration and another class elected by May Clinc. The Group Representative asserts that "[f]or non-profit corporations, being a 'member' is the equivalent of being an 'owner.'"

2. Demonstrates in the first sentence a strong Catholic identity and influence which, the Group Representative asserts, is not the case with other Mayo Clinic hospitals and is the differentiating factor between the two organizations.

Finally, the Group Rep asserts that Mayo Clinic-Eau Claire and Mayo Clinic-LaCrosse are not commonly owned or controlled because the Mayo Clinic-Eau Claire was a member of the Mayo Clinic Hospital System and, in contrast, the Mayo Clinic-LaCrosse was part of Mayo Health Clinic System—Franciscan Healthcare, Inc.

A review of the Board's docket for later years demonstrates that Mayo-Clinic LaCrosse and Mayo Clinic-Eau Claire are related and were under ownership and/or control of the Mayo Clinic Health System and that they are both subject to CIRP rules. In its initial response to the Board, Hall Render represented that there was no change in ownership structure for the Mayo Health Clinic System—Franciscan Healthcare, Inc. between 2012 and 2018:

> It is important to note that *during fiscal year ending 12/31/2012*, May Clinic Health System – Franciscan Healthcare LaCross was *a dual sponsorship* between Mayo Clinic Health System and Franciscan Healthcare, ***which did not change until October 2018***

[54] (Italics emphasis added and bold underline emphasis in original.)

> when the Franciscan Sisters of Perpetual Adoration relased their sponsorship

The Board reviewed the By-Laws that the Group Representative included with its second response; however, neither this document nor the Group Representative's response satisfactorily explains the relationship between the corporate entities, much less a clear picture of the ownership and control of both Mayo Clinic-LaCrosse in comparision with that for Mayo Clinic-Eau Claire. In this regard, the Board notes that it is not enough to show no "ownership" as a party can be related by "control" since 42 U.S.C. § 1395oo states that "[a]ny appeal to the Board or action for judicial review *by providers which are* ***under common ownership <u>or</u> control*** . . . *must* be brought by such providers *as a group* with respect to any matter involving an issue common to such providers." For example, the By-Laws (effective May 23, 2011) are between the "Mayo Foundation" (as opposed to the "Mayo Clinic Health System") and the Franciscan System and an unidentified "FSPA" and create an oranizaiton identified as the "Mayo Clinic Health System-Franciscan Healthcare, Inc." having defined "specific and primary purposes":

> 1. *to provide* ***support*** exclusively to and for the benefit of, and supervised by or controlled in connection with entities including. . . .
>
> 2. *to provide planning* and coordination of health care services . . . .
>
> 3. to engage in long-term *planning*, financing and, fundraising . . . .
> 4. to perform *planning* and feasibility studies . . . .
>
> 5. to serve as the member or Shareholder of other corporations, administering their corporate affairs in accordance with the philosophy and values of the congregation and of the Ehtical Directives;
>
> 6. *To otherwise support* and benefit general health, educational, religious and charitable works of the Congregation . . . .
>
> 7. to serve as the parent and integrating entity to form an integrated healthcare delivery network involving the physician practice previously organized as Skemp Clinic, Ltd., Mayo Foundation, and other entities . . . ." [55]

However, neither these purposes nor the By-Laws, in general, establish any clear control or ownship of any hospitals and, in particular, make no specific reference to Mayo Clinic-LaCrosse or Mayo Clinic-Eau Claire, thereby on their face fail to establish any "ownership" or "control" of the Mayo Clinic-LaCrosse.[56]

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[55] (Empahsis added.)
[56] Similarly, the Board reviewed the webpage sited by the Group Representative: https://www.mayoclinichealthsystem.org/locations/la-crosse/about-us/history. However, this webpage suggests that *all* Mayo Clinic locations were part of the dual sponsorship: "In May 2011, ***all*** health system locations adopted the common name of Mayo Clinic Health System in (town name). To reflect the dual sponsorship at the time, all former Franciscan Skemp locations became known as Mayo Clinic Health System— Franciscan Healthcare in (town

Similarly, the Group Reprsentative provided an organization chart as Exhibit P-4 allegedly addressing ownership of the Mayo Clinic Health System—Franciscan Healthcare, Inc. However, this organization chart provides no useful information as neither Mayo Clinic-LaCrosse nor Mayo Clinic-Eau Claire are specifically addressed in this chart. Indeed, this chart does not even show the Mayo Clinic Health System—Franciscan Healthcare, Inc. on that organization chart.

In support of its finding that the Mayo Clinic Health System owns and controls both Mayo Clinic-LaCrosse and Mayo Clinic-Eau Claire during 2012 to 2018, the Board takes administrative notice that the Group Representative has established and pursued other CIRP groups ***for the Mayo Clinic Health System*** for 2013, 2015 and 2016 and represented in these CIRP groups that Mayo Clinic-Eau Claire and Mayo Clinic-LaCrosse are related by ownership and/or control because these CIRP groups include ***both*** Mayo Clinic-Eau Claire and Mayo Clinic-LaCrosse as participants in said CIRP groups. As noted above, the Board's second request for information highlighted this fact for the Group Representative. Indeed, the Board has since identified at least 6 different CIRP groups ***for the Mayo Clinic Health System*** for 2013, 2015, and 2016 (3 for 2013, 1 for 2015 and 2 for 2016) in which ***both*** Mayo Clinic-Eau Claire ***and*** Mayo-LaCross are participants or, where the case was fully adjudicated, were participants.[57] Moreover, the Board notes that, in each of these 6 CIRP groups, Mayo Clinic-LaCrosse is identified in the Scheudle of Providers in OH CDMS as "Mayo Clinic Health System Franciscan Medical Center La Crosse 52-0004" while, in contrast for this optional group case, it is simply identified on the Schedule of Providers as "Mayo Clinic-LaCrosse." Notwithstanding, the Group Representative has failed to reconcile its position regarding ownership and control of the Mayo Clinic-LaCrosse in Case No. 19-0622G with its inclusion of Mayo Clinc-LaCrosse as a participant in most (if not all other) CIRP groups ***for the Mayo Clinic Health System*** during the 2012 to 2018 period.

The Board has ***twice*** asked for information from the Group Representative and the Group Representative, notwithstanding the Board inquiry, has failed to provide sufficient information to establish that Mayo-Clinic Eau and Mayo Clinic-LaCrosse were not related by ownership or control during 2012. Accordingly, based on the facts before it, the Board must conclude that the Group Representative has consistently pursued Mayo Clinic Health System CIRP groups for 2013, 2015, and 2016 with both Mayo Clinic-Eau Claire and "Mayo Clinic Health System Franciscan Medical Center La Crosse 52-0004" as participants and that the Group Representative has confirmed that dual sponsorship of Mayo Clinic Health System-Franciscan Healthcare, Inc.

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name)." Indeed, this was the webpage refrenced in the Board's letter in which the Board stated it appears as if Mayo Clinic-LaCrosse was owned by Mayo Clinic Helath System—Franciscan Healthcare.

[57] *See, e.g.*, Case No. 17-0364GC entitled "Mayo Clinic Health System Pre 10/1/2013 DSH Medicare/Medicaid Part C Days Group" (EJR denied on 12/18/2020 and remanded per CMS Ruling 1739-R on 1/29/2021); Case No. 17-0366GC entitled "Mayo Clinic Health System 2013 DSH SSI Fraction Dual Eligible Days CIRP" (EJR granted 6/16/2021); Case No. 17-0369GC entitled "Mayo Clinic Health System 2013 DSH Post 1498R Data Match CIRP Group"; Case No. 19-2549GC entitled "Mayo Clinic CY 2015 DSH SSI Fraction Eligible Days CIRP Group" (EJR granted 7/22/2021); Case No. 20-1341GC entitled "Mayo Clinic CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group"; and Case No. 21-1327GC entitled "Mayo Clinic CY 2016 DSH SSI Post 1498R Data Match CIRP Group."

was otherwise consistent from 2012 through 2018,[58] the Mayo Clinic-LaCrosse and Mayo Clinic-Eau Claire are related and/or controlled *by the Mayo Clinic Health System.*

Based on the record, it is clear that the Mayo Clinc-Eau Claire for FY 2012 was granted an EJR on June 1, 2018 as part of an optional group notwithstanding the fact that the Mayo Clinic-Eau Claire was related to Mayo Clinic-LaCrosse and that they were required to bring their 2012 appeals of the SSI Dual Eligible Days issue together as part of a CIRP group appeal. Pursuant to 42 U.S.C. § 1395oo(f)(1) states:

> Any appeal to the Board or action for judicial review by providers which are *under common ownership or control . . .* ***must*** be brought by such providers ***as a group*** with respect to any matter involving an issue common to such providers.[59]

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation:

> Two or more providers ***under common ownership*** ***or*** ***control*** that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, ***must*** *bring* the appeal as a group appeal.[60]

Subsection (e) requires that the group provider provide notice that the group is fully formed and complete. Once the group is certified as complete, restrictions are placed on the ability for additional providers under common ownership:

> When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, *absent an order from the Board modifying its determination*, ***no other provider under common ownership or control may appeal*** to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.[61]

Pursuant to the 42 U.S.C. § 1395oo(f)(1) and the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e), commonly owned or controlled providers of the Mayo Clinic Health System are required to bring issues common to them for a particular year as part of a CIRP group. Here, it is clear that Mayo Clinic-Eau Claire and Mayo Clinic-LaCrosse were owned or controlled by the Mayo

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[58] As noted above, the Board has not been able to connect the dots between the Mayo Clinic Helath System-Franciscan Healthcare, Inc. and the Mayo Clinic-LaCrosse which is also referred to as "Mayo Clinic Health System Franciscan Medical Center La Crosse 52-0004" in the 2013, 2015, and 2016 CIRP groups.
[59] (Emphasis added.)
[60] (Emphasis added.)
[61] (Emphasis added.)

Clinic Health System during 2012 (and are still currently owned or controlled by the Mayo Clinic Health System as confirmed by the Group Representative). Accordingly, for 2012, they were required to bring their appeals of the common issue, the SSI Dual Eligible Days issue together as part of a CIRP group appeal for 2012. As the related provider, Mayo Clinic-Eau Claire, has fully adjudicated the SSI Dual Eligible Days issue for 2012 as part of an *optional* group under Case No. 15-2644G (for which the Board granted EJR on June 1, 2018), the Board finds that, consistent with 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(b)(1) and (e), the Mayo Clinic Health System has extinguished its ability to pursue appeals of the same issue for 2012 by any other provider commonly owned or controlled by Mayo Clinic Health System (including but not limited to the Mayo Clinic-LaCross), whether as part of a group (optional or CIRP) or as part of an individual appeal.

Accordingly, based on the above findings, the Board dismisses hereby dismisses Mayo Clinic – Lacrosse (Prov. No. 52-0004, FYE 12/31/12) because it violated the CIRP statute and regulations in pursing its appeal of the SSI Dual Eligible Days issue for 2012 as part of this *optional* group. Further, the Board must deny the EJR request as it relates to the Mayo Clinic-LaCrosse because jurisdiction is a prerequisite to EJR and the Board has no jurisdiction over Mayo Clinic-LaCrosse since Mayo Clinic-LaCrosse failed to pursue the issue as part of CIRP group as required by the CIRP statute and regulations.

(2) Jurisdiction over Participant No. 5, Weirton Medical Center (Prov. No. 51-0023)

Provider No. 5, Weirton Meidcal Center ("Weirton") was directly added to this optional group on February 4, 2019 based on its appeal of a revised NPR dated August 10, 2018. As set forth below, the Board finds Weirton did not have the right to appeal the SSI Dual Eligible Days issue from the revised NPR.

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

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

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

42 C.F.R. § 405.1835(a) sets forth a provider's right to appeal to the Board and confirms in paragraph (1) that, when a provider appeals from a revised NPR, "any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§ 405.1887(d), 405.1889(b) . . .)." Similarly, 42 C.F.R. § 405.1837(a) governing a provider's right to participate in group appeals specifies that the provider may only participate if it "satisfies individually the requriemetns for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement in § 405.1835(a)(2) or § 405.1835(c)(3)."

Here, the record reflects that, on August 20, 2015, Weirton requested a reopening of its FY 2012 cost report relative to the NPR issued on July 1, 2015 in order to add "[t]he attached DSH patient days . . . to the amounts previously submitted" relating to Worksheet S-2, Part 1, Columns 1 & 2 for Line 24 and Worksheet E, Part A, Line 4.03. On April 20, 2016, the Medicare Contractor issued a Notice of Repening for the July 1, 2015 NPR "[t]o modify the DSH% at Worksheet E Part A, Line 33 and ***include the additional Medicaid patient days (paid and eligible)*** at Worksheet S-2 Part I, Clumns 1 and 2, Line 24, and Worksheet S-3, Part I, Column 7, Line 2."[62] On August 10, 2018, the Medicare Contractor issued the revised NPR.

On February 4, 2019, Weirton filed a request to be directly added to this group directly added to this optional group on February 4, 2019 based on its appeal of the revised NPR and cited Audit Ajustment Nos. 1 and 2 to support its appeal request. Audit Adjustment No. 1 was made "[t]o adjust Medicaid days per reopening request by the provider. The additional requested accoutns were reviewed and 92 days were determined to be allowable. It was determined 4 days were not allowable as the patient(s) were not Title XIX" and, in this regard, "in-state Medicaid paid days", "in-state Medicaid eligible unpaid days", and "HMO and other were adjusted." Audit Adjustment No. 2 was made "[t]o adjust the DSH payment percentage to agree to the MAC's calculation."

As demonstrated by the reopening request, notice of reopening, and audit adjustment report accompanying the revised NPR, the revised NPR did not adjust the SSI percentage, much less any days for patients who were entitled to both SSI and Medicare Part A. Rather, the only item adjusted was the Medicaid fraction concerning patient who were not entitled to Medicare Part A but who were eligible for Medicaid. The Group's issue has nothing to do with the Mediciad fraction as the Group is contenting that the SSI fraction is understated and the Group is seeking to add days to the participant's SSI fraction. As the SSI Dual Eligible Days issue was not

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[62] (Emphasis added.)

specifically adjusted in the revised NPR, Weirton did not have a right under 42 C.F.R. § 405.1889(b) (as referenced in 42 C.F.R. § 405.1835(a) which is incorporated, in pertinent part, into § 405.1837(a)) to appeal the SSI Dual Eligible Days issue.

The only manner in which the Board has determined that it has jurisdiction over the SSI Dual Eligible Days issue *in the context of a revised NPR* is if: (1) the SSI percentage is specifically adjusted for SSI days; ***or*** (2) the data match process is rerun and generates a new and different SSI percentage where the Board must necessarily assume that there was a change in the underlying month-by-month data and that the SSI days included in that month-by-month data also were changed.[63] Here, the SSI percentage clearly was not adjusted for SSI days and, unless there is evidence to the contrary (which there is not), the Board must presume the underlying data in the SSI fraction was not changed for the Providers since there was no change in its SSI percentage. Accordingly, if Weirton wished to appeal or contest the SSI Dual Eligible Days issue for FY 2012, it should have appealed that issue from its original NPRs when it clearly had the right to do so since appeals of any potential future RNPRs is limited to matters "specifically revised."

In summary, because there was no revision to the SSI Dual Eligible Days issue (much less the SSI percentage) in Weirton's revised NPR, Weirton did not have a right under 42 C.F.R. § 405.1889(b) (as referenced in 42 C.F.R. § 405.1835(a) which is incorporated, in pertinent part, into § 405.1837(a)) to appeal to appeal the SSI Dual Eligible Days issue. Accordingly, the Board hereby dimisses Weirton from the optional group for lack of jurisdiction and denies Weirton's EJR request as jurisdiction is a prerequisite for jurisdiction. 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).[64] Therefore, the Board also denies the EJR request as it relates to Weirton as jurisdiction is prerequisite to EJR.

(3) Jurisdiction for the Remaining Participants

Based on its review of the record, the Board finds that each of the *remaining* participants in this appeal filed timely and proper appeals. In this regard, the Board finds that the above Providers

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[63] This second situation does ***not*** encompass a realignment of the SSI percentage because CMS does ***not*** rerun the data match process in order to effectuate a realignment but rather uses pre-existing data previously gathered on a month-by-month basis to effectuate the realignment. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis); 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)).

[64] *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).

are governed by *Bethesda* or CMS Ruling CMS-1727-R and that the above Providers' appeals are permitted as they are challenging the substantive and procedural validity of a regulation.

The participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[65] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the *remaining* underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a *revised* data match.[66] The Secretary also stated in the Ruling that, where cost reports had not been settled, those providers SSI fraction would be calculated using the *revised* data match process to be published through rulemaking.[67]

Contemporaneous with CMS Ruling 1498-R[68] the Secretary published a proposed IPPS rule[69] which proposed to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the 2011 Final IPPS Rule in which the Secretary explained that:

> . . . we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[70]

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[65] *See* 42 C.F.R. § 405.1837.
[66] CMS Ruling 1498-R at 27.
[67] *Id.* at 31.
[68] *Id.* at 5.
[69] 75 Fed. Reg. 23852, 24002-07.
[70] 75 Fed. Reg. at 50277.

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[71] which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[72]

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

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[73] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

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

[71] (Medicare) Enrollment Database.
[72] 75 Fed. Reg. at 50285.
[73] 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 . . . ."

C. Board's Decision Regarding the EJR Request

The Board makes the following findings:

1) Provider # 6 Mayo Clinic – Lacrosse (Prov. No. 52-0004, FYE 12/31/12) is dismissed for violation of the CIRP regulation, 42 C.F.R. § 405.1837(b)(1));

2) Provider #5 Weirton Medical Center (Prov. No. 51-0023, FYE 6/30/2012) is dimissed for lack of jurisdiction under 42 C.F.R. § 405.1889(b) (as referenced in 42 C.F.R. § 405.1835(a) which is incorporated, in pertinent part, into § 405.1837(a));

3) It has jurisdiction over the matter for the subject year and that remaining participants listed on the schedule of providers attached to this decision are entitled to a hearing before the Board;

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

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

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

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation (as adopted in the preamble to the 2011 Final IPPS 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, the Board hereby closes the case.

Board Members Participating:

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For the Board:

9/22/2021

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RE: ***Jurisdictional Decision***
Ascension Health FFY 2021 Uncompensated Care Payments CIRP Group
Case No. 21-1011GC

Dear Ms. O'Brien Griffin,

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

Pertinent Facts:

On March 10, 2021, the Providers filed the CIRP group appeal request (within 180 days of the IPPS Final Rule), appealing the use of 2017 S-10 audits to calculate their FFY 2021 Uncompensated Care ("UCC") Payments. The Providers claim its UCC payments were understated for several reasons. First, that the process used by the Medicare Contractor ("MAC") when sampling the Uninsured Charity Care charges was flawed, not statistically valid, and improper.[1] They also claim that when determining the allowable uninsured Charity Care charges, the MAC did not follow the mandates of the applicable cost report instructions, resulting in audit adjustments that are arbitrary, capricious, and flawed.[2] In its Group Issue Statement, the Providers state:

> This Appeal centers on the procedurally unlawful policy of performing audits on Worksheet S-10 of only a limited number of DSH hospitals but used with all other DSH hospitals' unaudited S-10s' to calculate UC Payments for all DSH hospitals. CMS chose to arbitrarily audit Providers' Worksheet S-10 without issuing adequate S-10 Uncompensated Care cost reporting guidelines to Providers before any such requirements were imposed or required of Providers. Not only was this done without having adequate audit protocols in place, but even more, without going through adequate notice and comment requirements as required under the Medicare Act.[3]

[1] Providers' Appeal Request, Group Issue Statement (March 10, 2021).
[2] *Id.* at 2.
[3] Providers' Appeal Request at 1 (March 10, 2021).

The Providers argue that the S-10 was arbitrarily audited without CMS issuing adequate UCC reporting guidelines or going thorough adequate notice and comment requirements.[4] While they acknowledge that the estimates used by the Secretary for the UCC DSH payment is not subject to review, they claim that a procedural challenge regarding the way their Worksheet S-10 audits were conducted (with no prior notice of the standards and process to be utilized in the audit) is permissible.[5]

In its Jurisdictional Challenge, the MAC argues that the appealed group issue is *precluded* from administrative and judicial review ***pursuant to 42 U.S.C. § 1395ww(r)(3)***.[6] In support of its position, the MAC quotes some of recent decisions of the Board in which found that it does not have jurisdiction to review UCC payment issues pursuant to 42 U.S.C. § 1395ww(r)(3).[7] The MAC insists that the Board does not have the authority to address the majority of the Provider's arguments due to the preclusion of administrative and judicial review under this statutory provision, but nevertheless defends its audit of Provider's data as proper.[8]

On August 26, 2021, the Provider filed a response to the MAC's jurisdictional challenge. The Providers assert that they are not challenging either an estimate or a period but rather they are challenging CMS' violation of 42 U.S.C. § 1395hh(a)(2):

> Despite the fact that these audits establish a "statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services", CMS ignored the statutory mandate to publish it for notice-and-comment. 42 U.S.C. § 1395hh(a)(2). The 2017 S-10 Worksheet audit process impacted payment for providers who were subject to the audits and resulted in reductions in their UCDSH reimbursement. CMS refused to publish the protocols, rules, guidelines, or standards it implemented in choosing not only which hospitals to audit but also what protocols, rules, guideline or standards would govern those audits of hospitals' UC costs. CMS's Worksheet S-10 audit process violated 42 U.S.C. § 1395hh(a)(2).

Relevant Law and Analysis:

A. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and

[4] *Id.*
[5] *Id.*
[6] Medicare Administrative Contractor's Jurisdictional Challenge at 2 (July 27, 2021).
[7] *Id.* at 3-4.
[8] *Id.* at 3.

judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[9]
>
> (B) Any period selected by the Secretary for such purposes.

B. Interpretation of Bar on Administrative Review

1. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"),[10] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[11] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[12] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[13]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a

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[9] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[10] 830 F.3d 515 (D.C. Cir. 2016).
[11] 89 F. Supp. 3d 121 (D.D.C. 2015).
[12] 830 F.3d 515, 517.
[13] *Id.* at 519.

challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[14]

2. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[15] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[16] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[17]

3. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[18] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[19] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[20] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[21] Nevertheless, the Secretary used each

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[14] *Id.* at 521-22.
[15] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[16] *Id.* at 506.
[17] *Id.* at 507.
[18] 514 F. Supp. 249 (D.D.C. 2021).
[19] *Id.* at 255-56.
[20] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[21] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.

hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[22]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[23]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[24] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[25] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[26]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[27] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

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[22] *Id*.
[23] *Id*. at 262-64.
[24] *Id*. at 265.
[25] *Id*. (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[26] *Id*. at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[27] *Id*. at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).

4. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[28] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[29] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judiciao review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs.""[30] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in Azar *v. Allina Health Servs*.[31] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[32]

Board Decision:

The Board finds that it does not have jurisdiction over the UCC DSH Payment issue in this CIRP group appeal, and hereby dismisses the CIRP group appeal. The Providers in Case No. 21-1011GC are arguing that the Secretary departed from its own policies contained in the relevant cost reporting instructions, and that the audit of the S-10 Worksheets was unlawful because the process did not undergo proper notice and comment rulemaking. With regard to any argument that related to the Medicare Contractor's alleged deviation from CMS' stated policy for making the UCC calculation, the D.C. District Court held in *Scranton* that such a challenge is barred from review, succinctly stating that any argument "that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[33]

While the Providers, here, do frame the issue as a narrow challenge centered on the procedural validity of a policy, it should be noted that the Group is preemptively appealing from *unissued* NPRs claiming that their own UCC payments should be adjusted. In *Tampa General*, the court rejected the characterization of a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded

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[28] Civ. No. 20-139, 2021 WL3856621 (D.D.C. August 30, 2021).
[29] *Id*. at *4.
[30] *Id*. at *9.
[31] 139 S. Ct. 1804 (2019).
[32] *Ascension* at *8 (bold italics emphasis added).
[33] *Scranton* at *10.

determination and increase their DSH UCC payments.[34] The same holds true for a similar characterization of a procedural challenge that ultimately challenges the underlying data or methodologies used to generate the estimates for a UCC DSH payment calculation.

Finally, the Board notes that, in *Ascension*, the D.C. Circuit squarely addressed the Providers claims that the S-10 Worksheets and associated audit process violated the statutory mandate in 42 U.S.C. § 1395hh(a)(2) to publish it for notice-and-comment. However, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars such claims. The Board applies and relies on the *Ascension* decision.

Accordingly, the Board dismisses Case No. 21-1011GC and removes it from the Board's docket. The Board notes that its ruling is consistent with the D.C. Circuit's decision in *Tampa General*, *DCH v. Azar*, and *Ascension* and that these decisions are controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[35] Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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For the Board:

9/22/2021

X Clayton J. Nix

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Signed by: PIV

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Administrators (J-8)

[34] *Tampa General* at 521-22.

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

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RE: ***Jurisdictional Decision***
Franciscan Alliance FFY 2021 Uncompensated Care Payments CIRP Group
Case No. 21-1013GC

Dear Ms. O'Brien Griffin,

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

Pertinent Facts:

The Providers filed the appeal request on March 10, 2021, (within 180 days of the IPPS Final Rule), appealing the use of 2017 S-10 audits to calculate their FFY 2021 Uncompensated Care ("UCC") Payments. The Group claims its UCC payment will be understated for several reasons. First, the process used by the Medicare Contractor ("MAC") when sampling its Uninsured Charity Care charges was flawed, not statistically valid, and improper.[1] They also claim that when determining the allowable uninsured Charity Care charges, the MAC did not follow the mandates of the applicable cost report instructions, resulting in audit adjustments that are arbitrary, capricious, and flawed.[2] In its Group Issue Statement, the Providers state:

> This Appeal centers on the procedurally unlawful policy of performing audits on Worksheet S-10 of only a limited number of DSH hospitals but used with all other DSH hospitals' unaudited S-10s' to calculate UC Payments for all DSH hospitals. CMS chose to arbitrarily audit Providers' Worksheet S-10 without issuing adequate S-10 Uncompensated Care cost reporting guidelines to Providers before any such requirements were imposed or required of Providers. Not only was this done without having adequate audit protocols in place, but even more, without going through adequate notice and comment requirements as required under the Medicare Act.[3]

[1] Providers' Appeal Request, Group Issue Statement (March 10, 2021).
[2] *Id.* at 2.
[3] Providers' Appeal Request at 1 (March 10, 2021).

The Group argues that its S-10s were arbitrarily audited without CMS issuing adequate UCC reporting guidelines or going thorough adequate notice and comment requirements.[4] While the Group acknowledges that the estimates used by the Secretary for the UCC DSH payment is not subject to review, it claims that a procedural challenge regarding the way its Worksheet S-10 audit was conducted (with no prior notice of the standards and process to be utilized in the audit) is permissible.[5]

In its Jurisdictional Challenge, the MAC argues that the appealed issue is precluded from administrative and judicial review ***pursuant to 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)***.[6] In support of its position, the MAC quotes some of recent decisions of the Board in which it found that it does not have jurisdiction to review UCC payment issues pursuant to 42 U.S.C. § 1395ww(r)(3).[7] The MAC insists that the Board does not have the authority to address the majority of the Group's arguments due to the preclusion of administrative and judicial review under this statutory provision, but nevertheless defends its audit of Group's data as proper.[8]

On August 31, 2021, the Provider filed a response to the MAC's jurisdictional challenge. The Providers assert that they are not challenging either an estimate or a period but rather they are challenging CMS' violation of 42 U.S.C. § 1395hh(a)(2):

> Despite the fact that these audits establish a "statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services", CMS ignored the statutory mandate to publish it for notice-and-comment. 42 U.S.C. § 1395hh(a)(2). The 2017 S-10 Worksheet audit process impacted payment for providers who were subject to the audits and resulted in reductions in their UCDSH reimbursement. CMS refused to publish the protocols, rules, guidelines, or standards it implemented in choosing not only which hospitals to audit but also what protocols, rules, guideline or standards would govern those audits of hospitals' UC costs. CMS's Worksheet S-10 audit process violated 42 U.S.C. § 1395hh(a)(2).

Relevant Law and Analysis:

A. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and

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[4] *Id*.
[5] *Id*.
[6] Medicare Administrative Contractor's Jurisdictional Challenge at 3 (August 2, 2021).
[7] *Id*. at 3-4.
[8] *Id*..

judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[9]
>
> (B) Any period selected by the Secretary for such purposes.

B. Interpretation of Bar on Administrative Review

1. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"),[10] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[11] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[12] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[13]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a

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[9] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[10] 830 F.3d 515 (D.C. Cir. 2016).
[11] 89 F. Supp. 3d 121 (D.D.C. 2015).
[12] 830 F.3d 515, 517.
[13] *Id.* at 519.

challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[14]

2. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[15] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[16] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[17]

3. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[18] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[19] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[20] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[21] Nevertheless, the Secretary used each

[14] *Id.* at 521-22.
[15] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[16] *Id.* at 506.
[17] *Id.* at 507.
[18] 514 F. Supp. 249 (D.D.C. 2021).
[19] *Id.* at 255-56.
[20] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[21] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.

hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[22]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[23]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[24] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[25] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[26]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[27] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

[22] *Id*.
[23] *Id*. at 262-64.
[24] *Id*. at 265.
[25] *Id*. (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[26] *Id*. at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[27] *Id*. at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).

4. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[28] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[29] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judiciao review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs.""[30] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in Azar *v. Allina Health Servs*.[31] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[32]

Board Decision:

The Board finds that it does not have jurisdiction over the UCC DSH Payment issue in this appeal, and hereby dismisses the appeal. The Providers are arguing that the Secretary departed from its own policies contained in the relevant cost reporting instructions, and that the audit of the S-10 Worksheets was unlawful because the process did not undergo proper notice and comment rulemaking. With regard to any argument that related to the Medicare Contractor's alleged deviation from CMS' stated policy for making the UCC calculation, the District Court for the District of Columbia held in *Scranton* that such a challenge is barred from review, succinctly stating that any argument "that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[33]

While the Providers here do frame the issue as a narrow challenge centered on the procedural validity of a policy, it should be noted that the Group is preemptively appealing from unissued NPRs claiming that their own UCC payments should be adjusted. In *Tampa General*, the court rejected the characterization of a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination and increase their DSH UCC payments.[34] The same holds true for a similar

[28] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[29] *Id*. at *4.
[30] *Id*. at *9.
[31] 139 S. Ct. 1804 (2019).
[32] *Ascension* at *8 (bold italics emphasis added).
[33] *Scranton* at *10.
[34] *Tampa General* at 521-22.

characterization of a procedural challenge that ultimately challenges the underlying data or methodologies used to generate the estimates for a UCC DSH payment calculation.

Finally, the Board notes that, in *Ascension*, the D.C. Circuit squarely addressed the Providers claims that the S-10 Worksheets and associated audit process violated the statutory mandate in 42 U.S.C. § 1395hh(a)(2) to publish it for notice-and-comment. However, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars such claims. The Board applies and relies on the *Ascension* decision.

Accordingly, the Board dismisses Case No. 21-1011GC and removes it from the Board's docket. The Board notes that its ruling is consistent with the D.C. Circuit's decision in *Tampa General*, *DCH v. Azar*, and *Ascension* and that these decisions are controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[35] Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

<u>Board Members Participating</u>:

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For the Board:

9/22/2021

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Administrators (J-8)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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<u>Via Electronic Delivery</u>

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RE: ***EJR Determination***
CY 2008 DSH SSI Fraction Dual Eligible Days Group III
Case No. 18-0336G

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 20, 2020 request for expedited judicial review ("EJR") in the above-referenced appeal. The Board's decision with respect EJR is set forth below.

<u>Effect of COVID -19 on Board Operations</u>:

By letter dated April 15, 20200, the Board sent the Group Representative notice for these groups that the 30-day time period for issuing an EJR had been stayed consistent with Board alert 19. As explained below, that stay remains in effect. On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On April 15, 2020, subsequent to the submission of the EJR request, the Board notified you of the Issue in relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned group appeals.

Although the ***hard copy*** Schedules of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom prior to the issuance of Alert 19, the Board did not receive the EJR request for the above-referenced appeals in its office until March 20, 2020, after the Board and its staff had begun to telework. Consequently, the Board did not have access to its office to locate the Schedules of Providers. Further, the Board has not resumed normal operations, but is

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

Issue in Dispute:

The issue for which the Board is considering EJR is:

> [W]hether the Providers' Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[1]

Medicare Disproportionate Share Hospital (DSH) Payment Background:

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

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –

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[1] Providers' EJR Request at 2.
[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[4] (Emphasis added.)

> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[5]

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

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

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

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic

[5] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[6] 42 U.S.C. § 1382.
[7] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[8] 20 C.F.R. § 416.202.
[9] 42 U.S.C. § 426.
[10] 42 U.S.C. § 426-1.

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

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

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

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[21] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[22] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[23] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring

[11] 20 C.F.R. § 416.204.
[12] 20 C.F.R. §§ 416.1331-1335.
[13] 20 C.F.R. §§ 416.1320-1330.
[14] 20 C.F.R. § 1320.
[15] 20 C.F.R. § 416.207.
[16] 20 C.F.R. § 416.210.
[17] 20 C.F.R. § 416.214.
[18] 20 C.F.R. § 416.215.
[19] 20 C.F.R. § 416.211.
[20] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[21] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[22] *Id.*
[23] *Id.*

in the federal fiscal year.[24] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[25]

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

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

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[24] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[25] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[26] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.
[27] CMS-1498-R at 5.
[28] *Id.*

"use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[29]

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

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[32] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[33] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[34] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[35] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[36]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the

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[29] *Id.* at 5-6.
[30] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[31] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[32] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[33] *Id.* at 50280.
[34] *Id.* at 50280-50281.
[35] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[36] *Id.* at 50285.

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

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

As a result of the Rulings, new regulation and data match process, CMS calculated new and recalculated existing SSI percentages for the Hospitals for all of fiscal years at issue in these appeals.[41] The Hospitals have appealed original NPRs based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

<u>Providers' Request for EJR</u>:

The Providers assert that under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration (SSA) for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[42]

The Providers note that in administering the SSI program, SSA assigns each beneficiary a Patient Status Code (PSC). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes,

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[37] CMS-1498-R at 6-7, 31.
[38] *Id.* at 28, 31.
[39] 75 Fed. Reg. at 24006.
[40] CMS-1498-R2 at 2, 6.
[41] The SSI ratios for FY 2009 and 2010 were published on March 16, 2012 and October 17, 2012, respectively. *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[42] 75 Fed. Reg. at 50,275-286.

C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[43] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the Medicare statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' DPP calculations which they are entitled to under Section 951 of the Medicare Prescription Drug, Improvement and Modernization Act, P.L. 108-173.

<u>Decision of the Board</u>:

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

A. Jurisdiction

1. Background on Jurisdiction

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the Dual Eligible Days issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[44] 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.[45]

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[43] *Id.* at 50,281.
[44] 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.).
[45] *Bethesda at 1258-59.*

On August 21, 2008, new regulations governing the Board were effective.[46] 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).*[47] 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.[48]

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

2. Dismissal of Participant Nos. 4 and 5

Participant Nos. 4 and 5 are both the same provider, namely the University of Wisconsin Hospitals (Prov. No. 52-0098) (hereinafter "UWH"), but for two fiscal years, FYE 6/30/2007 and 6/30/2008 respectively. UWH filed Requests for Hearing ("RFHs") for FYEs 6/30/2007 and 6/30/2008 in August, 2013 to which the Board assigned Case Nos. 13-3155 and 13-3156 respectively. UWH included an issue for "Disproportionate Share SSI Percent" in these RFHs:

> Issue 1: Disproportionate Share SSI Percent
>
> Medicare Regulations at 42 CFR §412.106 address the computation of the SSI percentage used in the determination of a hospital's disproportionate patient percentage. During the [fiscal year] field audit, the Intermediary improperly determined the Medicare DSH reimbursement by *not permitting the Provider to*

[46] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[47] 201 F. Supp. 3d 131 (D.D.C. 2016)
[48] *Banner* at 142.

> *obtain and reconcile the SSI data maintained by CMS with Provider records*, as noted in adjustment #[46 for FY2007 and 50 for FY 2008] (attached). The provider believes this is incorrect, and is appealing this adjustment.[49]

The Provider asserted that the estimated reimbursement impact for FY 2007 is $318,360 and for FY 2008 is $343,446. However, the Provider did not include *any* explanation or detail on how the estimated impacts were calculation or what they were based on.

On November 28, 2016, the Providers changed their representative to Hall, Render, Killian, Heath & Lyman ("Hall Render"). On January 31, 2017, Hall Render filed the Final Position Papers in these two individual appeals were.

As noted *supra*, the Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842 (2019). Under the implementing regulations, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue (as described in 42 C.F.R. § 405.1840); and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling. Further, under 42 C.F.R.§ 405.1842(e)(1), in relevant part, "[i]f the Board makes a finding that it has jurisdiction to conduct a hearing on a specific matter at issue in accordance with § 405.1840 . . . then (and only then) it must consider whether it lacks the authority to decide a legal question relevant to the matter at issue." Accordingly, a Board finding of jurisdiction is a *prerequisite* to any review of an EJR request.

Under 42 C.F.R. § 405.1840(b), the Board has jurisdiction to grant a hearing over a *specific* matter at issue in an appeal only if the provider has a right to a Board hearing as a single provider appeal under § 405.1835. The regulation at 42 C.F.R. § 405.1835 describes the right to a Board hearing and the content requirements of a hearing request. A provider's written hearing request must include certain elements. More specifically, under 42 C.F.R. § 405.1835(b)(2), a provider's written request for hearing must contain, for each *specific* item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the *specific* aspects of the final determination under appeal:

> (b) Contents of request for a Board hearing on final contractor determination. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request **must include the elements described in paragraphs (b)(1) through (b)(4) of this section**. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board may

[49] Individual Appeal Request, Tab 3 (PRRB Case 13-3155). The issue statement for PRRB Case 13-3156 is identical except it concerns FY08 and audit adjustment #50.

> dismiss with prejudice the appeal or take any other remedial action it considers appropriate. . . .
>
> (2) An explanation (**for each specific item at issue**, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal, **including an account of all of the following:**
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.

Accordingly, the regulations prescribe that if a provider submits a hearing request that *does not* meet the requirements of (b)(1), (2), or (3), the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.[50]

In keeping with the above-quoted regulation's specificity requirement, the Board's Rules in effect at the time that these Participants filed their Requests for Hearing ("RFH") state the following:

> **Rule 8—Framing Issues for Adjustment 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.)[51]

[50] 42 C.F.R. § 405.1835(b).
[51] Board Rule 8 (Mar. 1, 2013 (italics and underline emphasis added).

In addition, with respect to a party's preliminary position paper, the Board describes the following:

> **COMMENTARY**: Under the Regulations effective August 21, 2008, all issues will have been identified well in advance of the due date for preliminary position papers. Unlike the prior practice, preliminary position papers now are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.[52]

Further, Board Rule 25.1 specifies that a provider's preliminary position paper must include the following "content": (1) "[f]or each issue, state the material facts that support your claim"; (2) "[i]dentify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting your position"; and (3) "Provide a conclusion applying the material facts to the controlling authorities." Finally, the Board Rules gave the following instruction in Board Rule 25.2 for including exhibits to the preliminary position paper and for identifying unavailable documentation:

> **25.2 – Preliminary Documents:**
>
> **A. General**: With the preliminary position papers, *the parties must exchange all available documentation as preliminary exhibits* to fully support your position. The Intermediary must also give the Provider all evidence the Intermediary considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Intermediary believes is necessary for resolution which has not been submitted by the Provider.
>
> **B. Unavailable and Omitted Preliminary Documents**: *If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available.* Once the documents become available, promptly forward them to the opposing party.
>
> **C. Preliminary Documentation List**: Parties must attach a list of the exhibits exchanged with the preliminary position paper.[53]

[52] Board Rule 25 "Commentary" on page 25 (Mar. 1, 2013) (italics and underline emphasis added). *See also* Board Rule 23.3 Commentary (Mar. 1, 2013) ("Because the date for adding issues will have expired and transfers are severely limited, the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position.").
[53] Board Rule 25.2 (Mar. 1, 2013) (Underline and italics emphasis added).

Here, the Participants' RFHs issue for "Disproportionate Share SSI Percent" in Case Nos. 13-3155 and 13-3156 (filed in August, 2013) is set forth as follows:

> Issue 1: Disproportionate Share SSI Percent
>
> Medicare Regulations at 42 CFR §412.106 address the computation of the SSI percentage used in the determination of a hospital's disproportionate patient percentage. During the [fiscal year] field audit, the Intermediary improperly determined the Medicare DSH reimbursement by *not permitting the Provider to obtain and reconcile the SSI data maintained by CMS* with Provider records, as noted in adjustment #[46 for FY 2007 and 50 for FY 2008] (attached). The provider believes *this is incorrect*, and is appealing this adjustment.[54]

The Participants describe a very *non-specific* Disproportionate Share SSI Percent issue where the primary complaint is that the Provider was not permitted "to obtain and reconcile the SSI data maintained by CMS with Provider records" and that "this is incorrect." To this end, while the Provider includes a very specific dollar amount as the estimated reimbursement impact for each year ($318,360 for FY 2007 and $343,446 for FY 2008), it fails to provide any explanation for how those estimated reimbursement impact were calculated or what they were based on.

When considering the specificity of the "contents" requirements in 42 C.F.R. § 405.1835(b), the Board finds this Disproportionate Share SSI Percent issue statement to be deficient because the RFHs in Case Nos. 13-3155 and 13-3156 failed to meet the "contents" requirements in subsection (b)(2). More specifically, the RFHs generically refer to impropriety in the SSI calculation, but fail to include any description of any alleged errors much less explain "why . . . Medicare payment is incorrect for each disputed item" or "how and why Medicare payment must be determined differently for each disputed item."[55] The Board notes that, by the time the Participants filed their RFHs in 2013, there had been much litigation and several Agency publications describing certain systemic errors in the data matching process used to calculate SSI percentages:

1. *Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. 2006-D20 (Mar. 17, 2006), *rev'd by* CMS Adm'r Dec. (May 11, 2006).
2. *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
3. CMS Ruling 1498-R (April 28, 2010); and
4. 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (adopting a new data matching process post *Baystate*).

[54] Individual Appeal Request, Tab 3 (PRRB Case 13-3155) (emphasis added). The issue statement for PRRB Case 13-3156 is identical except it concerns FY08 and audit adjustment #50.
[55] (Emphasis added.)

However, none of these documents nor the detailed errors described therein are referenced in the RFHs. Not only is the appeal statement too vague, it clearly does not refer to any dual eligible days issue or any issue with SSI days and, accordingly failed "to give the parties a thorough understanding of their opponent's position"[56] and "to narrow the issues."[57] More importantly, there is no discussion or reference to SSI entitlement or SSI status or SSI-related MMA § 951 data issues.[58] In this regard, the Provider's whole premise regarding the SSI Fraction Dual Eligible Days issue is a purely ***legal*** issue grounded in the data match methodology set forth in the FY 2011 IPPS Final Rule (as discussed *infra*) and, as such, there was nothing preventing the Provider from explaining in its FY 2007 and 2008 requests for hearing "How and why the provider believes Medicare payment must be determined differently for each disputed item" in compliance with 42 C.F.R. § 405.1835(b).[59] Accordingly, on this basis alone, the Board may dismiss the EJR requests for lack of jurisdiction.

Finally, the Board notes that the first place in the FY 2007 and 2008 appeals that the Provider raises the SSI dual eligible days issues (SSI entitlement and SSI status codes) and associated SSI-related MMA § 951 data access issues is in the context of the Provider's final position papers.[60] The fact that, between the filing of their RFHs and their final position papers, the Providers engaged Hall Render to act as their designated representative does not give the Providers license to otherwise change, alter, amend, or otherwise transform the Disproportionate Share SSI Percent issue that they appealed into something else. As provided by 42 C.F.R. § 405.1835(e), there is only a limited 60-day window in which to add issues to an appeal and that window had closed for several years prior to the Providers' filing of their final position papers in January 2017.

Thus, the Board concludes that the description of Participant Nos. 4 and 5 issue titled Disproportionate Share SSI Percent in their RFHs does not comply with the regulatory specificity

[56] Board Rule 23.2 Commentary (Mar. 1, 2013) ("Because the date for adding issues will have expired and transfers are severely limited, the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position.").
[57] 42 C.F.R. § 405.1853(b)(1).
[58] The Board notes that the August 16, 2010 final rule adopting the new data matching process discusses in significant detail the SSI status codes used to determine SSI entitlement. 75 Fed. Reg. at 50280-81.
[59] The fact that UWH may have issues quantifying that *legal* issue for FYs 2007 and 2008 has no bearing on the Provider's obligation under 42 C.F.R. § 405.1835(a)-(b) to identify in its appeal request the specific item it wishes to appeal to the Board for FY 2007 and 2008 and to provide an explanation on "How and why the provider believes Medicare payment must be determined differently for each disputed item." As a result, it would be a red herring to suggest that the Provider needed access to certain data underlying the SSI percentage in order to be able to identify the purely ***legal*** issue that is being raised in the group issue statement in Case No. 18-0336G for FY 2007 and 2008.
[60] In this regard, the Board notes that Hall Render did ***not*** file the UWH's preliminary position papers for FYs 2007 and 2008, but rather those were filed by UWH itself. As a result, the Board suspects that, even though Board Rules require each party to fully brief its issues in its preliminary position paper (as discussed *supra*), UWH likely did not discuss or brief the issue *that is the subject of this group appeal* in its preliminary position papers filed for FYs 2007 and 2008. Based on the record before it, the Board believes it has sufficient information in the record upon which to base a dismissal because UWH's requests for hearing for FY 2007 and 2008 clearly do not meet the specificity requirements in 42 C.F.R. § 405.1835(a)-(b) to allow the Board to find that the SSI Duel Eligible Days was included within those requests for hearing. Otherwise, if it *were* unclear, the Board would have requested that UWH submit copies of the preliminary position papers that it exchanged with the Medicare Contractor for FYs 2007 and 2008 to determine whether UWH fully briefed that issue or otherwise abandoned that issue in its preliminary position paper.

requirements mandated for a Board hearing.[61] As jurisdiction is a prerequisite to EJR, the Board also denies the EJR request as it relates to Participants 4 and 5.

3. Jurisdiction for the remaining participants – Participant Nos. 1, 2, and 3

The participants that comprise the group appeal within this EJR request have filed appeals involving calendar year 2008. The Board has determined that Participants Nos. 1, 2, and 3 in the Schedule of Providers have fiscal years governed by the holding in *Bethesda* or CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000 in each appeal, as required for a group appeal.[62] The appeals were timely filed and included the issue within the instant EJR request. Based on the above the Board finds that it has jurisdiction for these three Providers in the above-captioned appeal. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Analysis Regarding the Appealed Issue

As noted above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a revised data match.[63] The Secretary also stated in the ruling that, where cost reports had not been settled, those providers SSI fraction would be calculated using the revised data match.[64] Contemporaneous with CMS Ruling 1498-R[65] the Secretary published a proposed IPPS rule[66] which proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the 2011 Final IPPS Rule in which the Secretary explained that:

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

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[61] *See* 42 C.F.R. § 405.1835(b).
[62] *See* 42 C.F.R. § 405.1837.
[63] CMS Ruling 1498-R at 27.
[64] *Id.* at 31.
[65] *Id.* at 5.
[66] 75 Fed. Reg. 23,852, 24,002-07.

> matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[67]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[68]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[69]

The Secretary did not incorporate the above new policy involving the revised data match process into the Code of Federal Regulations. However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a binding data match process to be used by the Medicare Contractors in calculating (or recalculating) providers SSI fractions.

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[70]

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

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[67] 75 Fed. Reg. at 50,277.
[68] (Medicare) Enrollment Database.
[69] 75 Fed. Reg. at 50,285.
[70] 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 . . . ."

C. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board, ***except for*** Participant Nos. 4 and 5 (University of Wisconsin Hospitals, Prov. No. 52-0098 for FYEs 6/30/2007 and 6/30/2008);

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

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

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

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation (as published in the FY 2011 Final Rule) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR (except for Participant Nos. 4 and 5 (University of Wisconsin Hospitals, Prov. No. 52-0098 for FYEs 6/30/2007 and 6/30/2008)) for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes this CIRP group case.

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

FOR THE BOARD:

9/23/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

Enclosures: Schedule of Providers

cc: Wilson Leong, Esq., CPA, FSS
Pam VanArsdale, National Government Services, Inc. (J-6)

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RE: ***Board Own Motion EJR Decision***
Nazareth Hospital (Prov. No. 39-0204)
FYEs 12/31/2007, 12/31/2008, 12/31/2009
Case Nos. 14-2205, 14-0997, 14-2324

Dear Messrs. Coyle and Snyder:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced three (3) individual appeals. The Board has decided that expedited judicial review ("EJR") is appropriate for the bad debt issue contained in these three appeals is set forth below.

Issue in Dispute:

The issue for which the Board has considered own motion EJR is:

> Nazareth Hospital included as a protest item on the cost report [for] the amounts of Medicare coinsurance and deductible amounts of Pennsylvania Medicaid Secondary accounts that would have been included in bad debt expense, but could not because of the Centers for Medicare and Medicaid Services (CMS) "must bill" policy…
>
> The CMS current interpretation of the Medicare bad debt regulations as related to dual eligible beneficiaries…[is] know as the "must bill" policy. In their interpretation of 42 C.F.R. § 413.89(e) "reasonable collection effort," CMS believes that …" in those instances where the state owes none or only a portion of the dual-eligible patient's deductible or co-pay, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the provider bills the State, and the State refuses payment (with a State Remittance Advice).

Background:

These three cases involve the 2007, 2008 and 2009 cost reporting periods. In order to initiate its own motion for EJR, the Board must issue a written notice to the parties, which they may

respond to, that identifies the issue and each relevant statute, regulation, or CMS Ruling.[1] On July 20, 2021, the Board advised the parties it was considering, on its own motion, whether it lacks the authority do decide the legal question, as stated above, in each of these appeals. The Board requested that the parties: (1) comment on the potential EJR, and (2) specifically address whether the record is complete for each party's position on the sole issue remaining in these cases concerning bad debts, or needs factual development through additional briefing and exhibits and/or the hearing process notwithstanding the potential EJR. Both the Provider and the Medicare Contractor have filed Comments in response to the Board's request.

The Board may now issue an EJR decision if it makes a finding that is has jurisdiction to conduct a hearing on the issue and that it lacks the authority to decide a legal question relevant to the issue.[2]

Statement of Facts and Relevant Law:

As part of the FY 2021 IPPS Final Rule, CMS codified the "must bill" policy and deemed it effective for cost reports ***before***, on, *or* after the effective date of its implementation (*i.e.*, October 1, 2021).[3] Hence, it is to be applied *retroactively* to cost reports *before* October 1, 2021 (*i.e.*, the effective date of the must bill codification). Specifically, the regulation at issue is 42 C.F.R. § 413.89(e)(2)(iii) which as amended states:

> (iii) *Indigent dual-eligible beneficiaries (including qualified Medicare beneficiaries).* Providers may deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid under a State's Title XIX Medicaid program as either categorically needy individuals or medically needy individuals. To be considered a reasonable collection effort for dual-eligible beneficiaries:
>
> **(A) When a State permits a Medicare provider's Medicaid enrollment for the purposes of processing a beneficiary's claim, to determine the State's liability for the beneficiary's Medicare cost sharing, the provider—**
>
> (1) Must determine whether the State's Title XIX Medicaid Program (or a local welfare agency, if applicable) is responsible to pay all or a portion of the beneficiary's Medicare deductible or coinsurance amounts;
>
> **(2) Must submit a bill to its Medicaid/Title XIX agency (or to its local welfare agency) to determine the State's cost sharing**

[1] 42 C.F.R. § 405.1842(c)(2).
[2] 42 C.F.R. § 405.1842(c)(1).
[3] *Id.* at 58989, 58900.

obligation to pay all or a portion of the applicable Medicare deductible and coinsurance;

(3) Must submit the Medicaid remittance advice received from the State to its Medicare contractor;

(4) Must reduce allowable Medicare bad debt by any amount that the State is obligated to pay, either by statute or under the terms of its approved Medicaid State plan, regardless of whether the State actually pays its obligated amount to the provider; and

(5) May include the Medicare deductible or coinsurance amount, or any portion thereof that the State is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt.

(**B) When, through <u>no fault of the provider</u>, a provider does not receive a Medicaid remittance advice** because the State does not permit a Medicare provider's Medicaid enrollment for the purposes of processing a beneficiary's claim, **<u>or because the State does not generate a Medicaid remittance advice</u>, the provider—**

(1) **Must submit** to its contractor, all of the following auditable and verifiable documentation:

(i) The State's Medicaid notification stating that the State has no legal obligation to pay the provider for the beneficiary's Medicare cost sharing.

(ii) A calculation of the amount the State owes the provider for Medicare cost sharing.

(iii) Verification of the beneficiary's eligibility for Medicaid for the date of service;

(2) Must reduce allowable Medicare bad debt by any amount the State is obligated to pay, regardless of whether the State actually pays its obligated amount to the provider; and

(3) May include the Medicare deductible or coinsurance amount, or any portion thereof that the State is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt.[4]

[4] (Bold and underline emphasis added.)

The preamble to the FY 2021 IPPS Final Rule describes this regulation as follows:

> After consideration of the public comments we received, we are finalizing our proposal to codify *our longstanding Medicare must bill bad debt policy* with respect to QMB dual eligible beneficiaries ***to require that the provider must bill the State for the QMB's Medicare cost sharing*** *and submit the resulting Medicaid RA the provider receives to Medicare to evidence the State's Medicare cost sharing liability,* so that any State Medicare cost sharing liability can be deducted from the Medicare bad debt reimbursement. *We are also codifying an alternate Medicaid RA documentation policy so that, in limited circumstances, providers can comply with the must bill policy and still evidence a State's cost sharing liability (or absence thereof) for dual eligible beneficiaries* ***when a State does not process a Medicare crossover claim and issue a Medicaid RA to providers***. In this regard, we are codifying that to be considered a reasonable collection effort for dual eligible beneficiaries when alternative documentation to the Medicaid remittance advice is submitted, a provider must submit all of the following: (1) The State Medicaid notification evidencing that the State has no obligation to pay the beneficiary's Medicare cost sharing or notification evidencing the provider's inability to enroll in Medicaid for purposes of processing a crossover cost sharing claim, (2) documentation setting forth the State's liability, or lack thereof, for the Medicare cost sharing, and (3) documentation verifying the beneficiary's eligibility for Medicaid for the date of service. *These policies are effective for cost reporting periods beginning* ***<u>before</u>****, on and after* ***the effective date of this final rule***.[5]

The Secretary has insisted that CMS has the statutory authority to *retroactively* codify these policies for dual eligible beneficiaries because it is merely clarifying longstanding requirements.[6]

The Board recognizes that prior litigation has addressed the Secretary's must bill policy. For example, the D.C. District Court holding in *Select Specialty Denver* contradicts the amended regulations at 42 C.F.R. § 413.89; however, this holding is not binding on the Board and, more importantly, it pre-dates and is superseded by the amended regulations. Similarly, in contrast, the Board notes the U.S. Circuit Court of Appeals for the D.C. Circuit recently reviewed and upheld the must bill policy.

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[5] 85 Fed. Reg. at 59003-04 (emphasis added). *See also id.* (stating "***when a State does not process a Medicare crossover claim and issue a Medicaid RA***, the provider could obtain, and submit to its Medicare contractor, some form of alternative documentation to evidence a state's Medicare cost sharing liability (or absence thereof)." (emphasis added)).

[6] *Id.* at 58902.

Regardless of these decisions, pursuant to 42 C.F.R. § 405.1867, the Board "***must** comply with* all provisions of Title XVIII of the [Social Security] Act and *the regulations thereunder*."[7]

Provider's Comments:

The Provider admits that *it did **not** bill Medicaid for these Outpatient accounts* but justifies not billing because: (1) there are costs associated with billing, and (2) its claim that Pennsylvania Medicaid will not pay for Medicare deductible and coinsurance where the Medicare payment is greater than the Medicaid payment.[8] The Provider asserts that these Outpatient accounts would have been Medicare bad debts, *but for* the Provider's compliance with the "must bill" policy. The Provider claims CMS' "must bill" policy has no foundation in law, is subject to notice and comment rulemaking, violates the bad debt moratorium, and is arbitrary and capricious.

The Provider asserts that, in the FY 2021 IPPS/LTCH PPS Final Rule,[9] CMS codified the bad debt provisions of the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM"), as well as CMS' interpretations of the PRM, including the "must bill" policy contained in Joint Signature Memorandum 370 ("JSM 370"). The Provider acknowledges that the notice and comment rulemaking of the FFY 2021 IPPS Final Rule revising the bad debt regulation; however, the Provider claims this rulemaking should not apply *retroactively* to the 2007, 2008 and 2009 fiscal years ("FY") at issue. The Provider contends CMS has exceeded its authority in making the bad debt revisions contained in the FFY 2021 IPPS Final Rule *retroactive* for cost reports beginning *before* the effective date of the final rule.

The Provider also argues that CMS' reliance on the "must bill" policy contained in JSM 370 should be questioned as a result of the Supreme Court's decision in *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019) ("*Allina*"). The Provider argues that the *Allina* case prohibits the government from establishing or changing an avowedly gap filling Medicare reimbursement policy without using notice-and-comment rulemaking. The Provider also cites to the U.S. District Court for the District of Columbia Circuit ("D.C. District Court") in *Select Specialty Hosp.-Denver, Inc. v. Azar*, 391 F. Supp. 3d 53 (D.D.C. 2019) ("*Select Specialty Denver*") in which the D.C. District Court ruled against the agency's application of the must-bill policy to a provider's earlier cost reporting periods of FY 2005 through FY 2010.

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[7] 42 C.F.R. § 405.1867 (emphasis added).

[8] These allegations are documented in protested items. For example in the as-filed cost report at issue in Case No. 14- 2205, the Provider included the following protested item description as documented in Exhibit P-4 for this case:

> Note: Due to the fact that M/A PA will not pay for Medicare deductible and coinsurance where the Medicare payment is greater than the M/A payment, and the cost associated with billing the M/A Outpatient, our hospital does not bill M/A for these O/P accounts. Based on the PRRB decision in Summer Hill Nursing Home, 2008-D5, where the Board found CMS "…'must bill' policy has no foundation in law…", we are including accounts that were written off as Medicaid contractual allowance as protested items that could have been Medicare bad debts, but for the CMS guidance & rulings – Bethesda.

[9] 85 Fed. Reg. 58432 (Sept. 18, 2020).

The Provider submitted comments regarding the Board's consideration of EJR (Aug. 13, 2021) in which it states the Board is not able to rule on the bad debt issue and the three appeals are ripe for EJR. The Provider refers to the fact that CMS made the Rule retroactive, and the Board must comply with all provisions of the Social Security Act. The Provider also states the record in these cases is complete as Final Position Papers and Supplemental Briefs have been filed.

Medicare Contactor Comments:

The Medicare Contractor opposes Board consideration of a Board own-motion EJR based on the fact that "the Provider's appeal requests for these appeals do not directly challenge the validity of a statute, regulation, or CMS ruling as required by PRRB Rule 42.1." Board Rule 42.1 states:

> A provider or group of providers may bypass the Board's hearing process and obtain expedited judicial review ("EJR") for a final determination of reimbursement that involves a challenge to the validity of a statute, regulation, or CMS ruling. Board jurisdiction must be established prior to granting an EJR request. In an appeal containing multiple issues, EJR may be granted for fewer than all the issues, in which case the Board will conduct a hearing on the remaining issues. The Board will make an EJR determination within 30 days after it determines that it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.

The Medicare Contractor asserts that "[t]he Provider is not directly challenging the legality of the must bill requirement, the 2021 Final Rule, or the 'must bill' policy contained in JSM 370 as a result of the *Allina* decision" but rather "is asserting that 'business reasons' excuses it from billing State Medicaid, an issue the Board has heard and ruled upon multiple times in the past." In summary, the Medicare Contractor asserts that "[t]he Board's jurisdiction over the issues is confined to the issues raised in its appeal."

Notwithstanding, the Medicare Contractor acknowledges that there are no factual issues in dispute.

Board Decision:

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

A. Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a), 42 C.F.R. § 405.1837 and 42 C.F.R. § 405.1835(a), a provider has a right to a Board hearing for specific items claimed for a cost reporting period covered by a final determination if it has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds it has jurisdiction to conduct a hearing on the specific matter at issue for all three fiscal year ends under appeal. In each of these three cases the Provider has requested a hearing within 180 days after receipt of its final determination, and the $10,000 amount in controversy requirement for an individual appeal has been met. Additionally, the Provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific issue under appeal by including the coinsurance and deductible amounts in question as protested items on the cost reports under appeal.

B. Board Finding Regarding Authority

The Board's notice of potential own-motion EJR identified the regulation at issue in these cases as 42 C.F.R. § 413.89(e)(2)(iii) as the FY 2021 IPPS/LTCH PPS Final Rule retroactively codified the "must bill" policy into that regulation. The Provider agrees with the Board's proposed own-motion EJR. Further, the Parties have confirmed in their Supplemental Briefs that there are factual issues in dispute. In this regard, the Board notes that, based on the record before it, it is clear to the Board that the Provider has conceded that it could have billed the Pennsylvania State Medicaid program for the bad debts at issue but chose for business reasons not to do so.[10]

Pursuant to 42 C.F.R. § 405.1867, the Board must comply with Title XVIII of the Act and its supporting regulations and this includes, but is not limited to, 42 C.F.R. § 413.89(e)(2)(iii) as retroactively codified pursuant to the FY 2021 IPPS/LTCH PPS Final Rule. The Providers' allege this regulation as codified by the FY 2021 IPPS/LTCH PPS Final Rule should not apply *retroactively* to FYs 2007, 2008 and 2009. The Provider makes the following contentions involving both procedural and substantive challenges to the validity of the retroactive codification of the must bill policy into the Code of Federal Regulations:

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[10] Stipulations for the Record at ¶ 9. *See also* Provider's Final Position Paper at 12 (stating "Similarly, had Nazareth Hospital submitted Outpatient claims to Pennsylvania Medicaid, *the claims would have been rejected since Pennsylvania Medicaid does not make payment as secondary* where Medicare would have paid more. Applying the court's reasoning in Summer Hill to Nazareth Hospital's situation, for the Secretary to deny the dual eligible bad debts based on the "must bill" policy without taking into account the fact that the Pennsylvania Medicaid program does not make payment as secondary when Medicare payment is higher, and therefore would have denied the claims, would be arbitrary and capricious."). Further, there is no argument raised in the Provider's Final Position Paper that it could not have enrolled in the Pennsylvania State Medicaid Program or otherwise billed the Pennsylvania State Medicaid Program. Rather, the Provider only raises futility arguments.

> CMS has **exceeded its authority** in making the must bill rule retroactive to the beginning of time, '…before, on and after the effective date of this final rule.', in part because **it ignores that the Bad Debt Moratorium remains in effect** for cost reporting periods beginning prior to October 12, 2012. The United States District Court for the District of Columbia has explained as follows that the Bad Debt Moratorium applies to any Medicare bad debt policy changes made either by the Secretary or by a provider. . . .
>
> Retroactive Rulemaking has been invalidated by the federal courts. . . . No provision of the Medicare Act supports the retroactive promulgation of the bad debt regulation. . . .
>
> In its open-ended retroactive application of the rule, CMS is attempting to circumvent the legal process for fiscal years prior to their acquiesce to court mandates that they use the formal process to be able to apply the JSM 370 must-bill rule. It is called notice and comment for a reason, there was no formal notice or opportunity for comment prior to the FFY 2021 IPPS final rule. The must-bill rule was not published int eh Provider Reimbursement Manual or the regulations at the time of the cost report under appeal. JSM 370 itself initially was not even readily available to Providers, it was only sent to Fiscal Intermediaries at the time.
>
> The procedural validity of the must-bill policy was called into question in light of the decision of the United States Supreme [*sic* Court] in *Azar v. Allina Health Services*. . . . Following the *Allina* requirement that CMS comply with notice and comment rulemaking, the Select Specialty Hosp.-Denver court held that the policy was required to be codified. Retroactive rule making does not cure the procedural defect. As noted above, the Bad Debt Moratorium remains in effective for periods prior to October 1, 2012.

The Board notes that the substantive aspect of the Provider's challenge to the validity of the retroactive codification of the "must bill" policy revolves around the Provider's claim that the retroactive codification of that policy violates the Bad Debt Moratorium.

The Board recognizes that the Medicare Contractor has raised objections to the Board's own-motion EJR by asserting that it would be inappropriate for the Board to do. The Board disagrees. The Provider's appeal requests for FYs 2007, 2008, and 2009 clearly concern the "must bill" policy and clearly challenge that policy by stating therein that the policy "has no foundation in

law."[11] The Medicare Contractor readily asserts in its Supplemental Brief that the retroactive regulations both codify the "must bill" policy and retroactively apply to the Provider's FYs 2007, 2008, and 2009; and that the Board is bound to apply those regulations retroactively to FYs 2007, 2008, and 2009.[12] Accordingly, it is within the Provider's right to challenge the retroactive application of those regulations which otherwise codify *on a retroactive basis* the "must bill" policy that it is challenging and which the Board is otherwise bound to apply to the Providers FYs 2007, 2008 and 2009 per 42 C.F.R. § 405.1867.[13]

Based on the above findings, the Board finds it lacks the authority to examine this legal question as it pertains to the bad debt issue under appeal in each of these three cases. In particular, the Board lacks the authority to grant the relief sought by the Providers, namely to declare the "must bill" policy as retroactively codified into 42 C.F.R. § 413.89(e)(2)(iii) by the FY 2021 IPPS/LTCH PPS Final Rule as invalid, whether substantively or procedurally.

C. Conclusion

With regards to this Board own motion EJR, the Board finds that:

1) It has jurisdiction over the specific matter at issue, and the Provider are entitled to a hearing before the Board in each of these cases covering FYs 2007, 2008, and 2009;
2) Based upon the Provider's assertion regarding the validity of 42 C.F.R. § 413.89(e)(2)(iii) as retroactively codified by the FY 2021 IPPS/LTCH PPS Final Rule, there are no findings of fact for resolution by the Board;
3) It is bound by Title XVIII of the Social Security Act and the regulations issued thereunder; and
4) It is without the authority to decide the legal question of whether the retroactive codification of the "must bill" policy into 42 C.F.R. § 413.89(e)(2)(iii) by the FY 2021 IPPS/LTCH PPS Final Rule is procedurally and/or substantively valid.

Accordingly, the Board finds that the question of the validity of the retroactively regulation at 42 C.F.R. § 413.89(e)(2)(iii) (as finalized in the FY 2021 IPPS/LTCH PPS Final Rule) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants, on the Board's own motion, EJR for the issue and the subject years. The Provider have 60 days from the receipt of

[11] Provider's appeal requests for FYs 2007, 2008, and 2009.
[12] *See, e.g.,* Medicare Contractor's Supplemental Brief Address the FY2021 Final Rule at 5 (stating "Simply put, *the Board* ***lacks the authority*** *to ignore CMS's* ***incorporation*** *of the 'must bill policy' into a regulation that* ***on its face is applicable*** *to the cost reporting [sic periods] under appeal*.... At best, *should the Board find a basis* ***not to apply*** *42 CFR 413.83(e)(2)(iii)*, the next step would be to adjudicate the dispute under the facts and the arguments on the merits presented in the respective Position Papers and reach a decision as it has done in numerous other bad debt appeals where the provider intentionally did not bill state Medicaid for purely business reasons." (Emphasis added)).
[13] Further, contrary to the Medicare Contractor's assertion, a plain reading of Board Rule 42.1 demonstrates that it does not bar the Board's own-motion EJR.

this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

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Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
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For the Board:

9/24/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson C. Leong, FSS
Edward Lau, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Stephanie Webster, Esq.
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RE: ***Expedited Judicial Review Determination***
HCA Pre 10/1/2013 DSH Medicare Advantage Plan Days CIRP Group
Case No. 15-0150GC

Dear Ms. Webster:

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

On October 7, 2020, the Providers in the above-referenced CIRP group appeal filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue, asking the Board to grant EJR despite the issuance of CMS Ruling 1739-R, and further challenging said Ruling.[2]

Effect of COVID -19 on Board Operations

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On October 7, 2020, the Providers in the above-referenced CIRP group appeal filed a request for EJR of the Part C Days issue, asking the Board to grant EJR despite the issuance of CMS Ruling 1739-R, and further challenging said ruling. On October 19, 2020, the Board issued an Alert 19 letter, which placed a stay on the EJR. In that correspondence the Board notified you of the

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).
[2] Providers' Petition for Expedited Judicial Review (Oct. 7, 2020), PRRB Case no. 15-0150GC.

relevance of Alert 19 to the EJR request, specifically, that the Board and the Centers for Medicare & Medicaid Services ("CMS") support staff have temporarily adjusted their operations and are maximizing telework for the near future. While Alert 19 explained that, whenever possible, the Board plans to continue processing EJR requests within 30 days, we emphasized that it must have access to the jurisdictional documents in order to review and issue an EJR decision…. "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); *see also* 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned group appeals.

Statutory and Regulatory Background

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[3] stated that:

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

[3] of Health and Human Services.

> including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[4]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[5]

With the creation of Medicare Part C in 1997,[6] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[7]

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 . . . .*[8]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[9] In response to a comment regarding this change, the Secretary explained that:

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

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[4] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[5] *Id*.
[6] 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.
[7] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[8] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[9] 69 Fed. Reg. at 49099.

> days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[10]

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.[11] 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).[12] 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."[13]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[14] 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

[10] *Id.* (emphasis added).
[11] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[12] *Id.* at 47411.
[13] 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).
[14] 746 F. 3d 1102 (D.C. Cir. 2014).

policy adopted in FFY 2005 IPPS rule.[15] In *Allina Health Services v. Price* ("*Allina II*"),[16] 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*.[17] 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.[18] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[19]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[20] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[21] The Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[22]

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

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these

[15] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[16] 863 F.3d 937 (D.C. Cir. 2017).
[17] *Id*. at 943.
[18] Id. at 943-945.
[19] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[20] CMS Ruling 1739-R (Aug. 17, 2020).
[21] *Id*.
[22] *Id*.

> consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[23]

Providers' Request for EJR

The Providers within the CIRP group appeal are challenging their Medicare reimbursement for the pre-10/1/2013 reporting period. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[24] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[25] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[26] As such, the Providers conclude that the Board is "required" to grant EJR.[27]

[23] CMS Ruling 1739-R at 6-7.
[24] Providers' Petition for Expedited Judicial Review, at 1 (Oct. 7, 2020).
[25] *Id*. at 1.
[26] *Id*.
[27] *Id*. at 1-2.

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[28] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[29]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here….[30]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz,* 536 U.S. 622, 627 (2002)).[31]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's

[28] *Id*. at 11-12.
[29] *Id*. at 21.
[30] *Id*. at 13-14.
[31] *Id*. at 14.

> attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[32]

Board's Analysis and Decision

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

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

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

Board's Authority

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

The Board's analysis is detailed below.

Jurisdictional Requirements for Provider ##1 and 74

In its review of the documentation for the remand of these providers, it was noted that two providers, Provider #1, Riverside Community Hospital (Prov. No. 05-0022), and Provider #74, HCA Houston Healthcare Southeast (Prov. No. 45-0097), for fiscal years ending in 2011 which were ***directly*** added to the group on May 31, 2019 and September 10, 2019, respectively.[33] In its letter asking for inclusion, the group representative for HCA Houston Healthcare Southeast (Prov. No. 45-0097) stated:

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[32] *Id.* at 17.

[33] Provider 1, Riverside Community Hospital (no. 05-0022), was added on May 31, 2019, and had a FYE 4/30/2011; Provider 74, HCA Houston Healthcare (Prov. No. 45-0097), was added on September 10, 2019, and had a FYE 12/31/2011.

> The purpose of this letter is to request that Bayshore Medical Center, provider number 45-0097, FYE 12/31/2011, be included in the above-referenced group appeal. *We are asking the Board to expand the 2013 group appeal to include this Provider's 2011 cost reporting period as it is related by common control to the hospitals in the group, and they are all appealing the same issue*.[34]

Notably, an identical letter was included for Riverside Community Hospital (Prov. No. 05-0022) utilizing the same reasoning.

Significantly, the Board has not yet ruled on this request to expand this CIRP group to include CY 2011 and, thereby, permit these two providers to join the group. The Board's ruling denying the expansion and dismissing these two 2011 providers is set forth below.

In making these expansion requests, the group representative *failed* to notify the Board that HCA previously had a CIPR group for 2011 for the same issue and year and that the Board had granted EJR in that group. In this regard, in reviewing the final Schedule of Providers and the EJR, it has come to the Board's attention that, on February 25, 2018, the Board granted Expedited Judicial Review ("EJR") request in the 2011 HCA CIRP group under Case No. 13-0236GC, *et al*, for the Part C days issue.[35] The group was entitled "HCA 2011 DSH - Medicare Advantage Plan Days CIRP Group" and represented the *same* parent organization, HCA Healthcare, and the *same* fiscal year as the provider at issue, 2011.

Pursuant to 42 U.S.C. § 1395oo(f)(1) states:

> Any appeal to the Board or action for judicial review by providers which are *under common ownership or control . . .* ***must*** be brought by such providers ***as a group*** with respect to any matter involving an issue common to such providers.[36]

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation:

> Two or more providers ***under common ownership <u>or</u> control*** that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, ***must*** *bring* the appeal as a group appeal.[37]

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[34] Schedule of Providers & Jurisdictional Documents, Provider 74 (Oct. 1, 2020) (emphasis added.
[35] EJR Determination (Feb. 25, 2018), PRRB Case No. 13-0236GC.
[36] (Emphasis added.)
[37] (Emphasis added.)

Subsection (e) requires that the group provider provide notice that the group is fully formed and complete. Once the group is certified as complete, no other provider under common ownership or control may then appeal the same issue for the same year, absent a Board order:

> When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, *absent an order from the Board modifying its determination*, ***no other provider under common ownership or control may appeal*** to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.[38]

Pursuant to the 42 U.S.C. § 1395oo(f)(1) and the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e), commonly owned or controlled providers are required to bring issues common to them for a *particular year* as part of a *single* CIRP group. Here, it is clear that the two FY 2011 providers in this appeal, were *not* included in the appropriate CIRP group, Case No. 13-0812GC, as required, but instead were added to a FY 2013 CIRP group, after the 2011 group had been fully formed and adjudicated. The Board finds that, consistent with 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(b)(1) and (e), Riverside Community Hospital (Prov. No. 05-0022) and HCA Houston Healthcare Southeast (Prov. No. 45-0097) for FY 2011 have extinguished their ability to pursue appeals of the *same* issue for 2011 whether as part of a group (optional or CIRP) or as part of an individual appeal.

As such, the Board hereby denies the group representative request to expand this CIRP group to encompass 2011 and dismisses Riverside Community Hospital (Prov. No. 05-0022) and HCA Houston Healthcare Southeast (Prov. No. 45-0097) for FY 2011 from this HCA CIRP group because the CIRP group for HCA 2011, PRRB Case No. 13-0812GC, was previously disposed of through the grant of an EJR. Pursuant to the CIRP statute and regulations, the 2011 appeals by Riverside Community Hospital (Prov. No. 05-0022) and HCA Houston Healthcare Southeast (Prov. No. 45-0097) were required to be included as part of the HCA 2011 CIRP group under Case No. 13-0236GC, for the same issue and year, rather than in this 2013 HCA CIRP group.

Jurisdictional Requirements for Remaining Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[39, 40]

[38] (Emphasis added.)
[39] 42 C.F.R. § 405.1835(a).
[40] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

The remaining Providers included in the instant EJR request were directly added to the CIPR groups based on the filing of appeals based on original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2013 (period prior to 10/1/13).

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[41] 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.[42]

On August 21, 2008, new regulations governing the Board were effective.[43] 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*").[44] 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.[45]

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

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[41] 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.).
[42] *Bethesda*, 108 S. Ct. at 1258-59.
[43] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[44] 201 F. Supp. 3d 131 (D.D.C. 2016).
[45] *Id.* at 142.

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

For Providers with appeals filed from original NPRs for cost reporting periods ending on or after December 31, 2008 but which began before January 1, 2016, CMS Ruling CMS-1727-R involves dissatisfaction with the Medicare Contractor determinations. The Board determines whether the participants' appeals involved with the instant EJR requests are governed by CMS-1727-R.[46] Based on its review of the record, the Board finds that each of the *remaining* participants in this appeal filed timely and proper appeals. In this regard, the Board finds that the above Providers are governed by *Bethesda* or CMS Ruling CMS-1727-R and that the above Providers' appeals are permitted as they are challenging the substantive and procedural validity of a regulation.

The participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[47] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the *remaining* underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[48] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[49] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[50] To date, CMS has yet to issue its new final rule.[51]

As the Providers' appeal concerns the FY 2013 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of*

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[46] Under ruling 1727-R, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.
[47] *See* 42 C.F.R. § 405.1837.
[48] (Emphasis added.)
[49] CMS Ruling 1739-R at 1-2.
[50] Id. at 2.
[51] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).

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

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[52] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

Validity of CMS Ruling 1739-R

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

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[53]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[54] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

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

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[55]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [56] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[57]

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[58] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all but two (dismissed below) providers within the instant group appeal;

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[55] *See Southwest* at 6-7.
[56] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[57] *See* CMS 1739-R at 8.
[58] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

2) The Board dismisses providers 05-0022, Riverside Community Hospital, and 45-0097, HCA Houston Healthcare Southeast from the group, as the CIRP group for HCA 2011, PRRB Case No. 13-0812GC, was disposed of through the grant of an EJR and is violation of the CIRP regulation, 42 C.F.R. § 405.1837(b)(1);

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

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

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

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

For the Board:

9/24/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson Leong, FSS
Byron Lamprecht, WPS Government Health Administrators

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RE: ***Own Motion Expedited Judicial Review Determination***
FFYs 2020 and 2021
Case No. 20-0817GC, *et al.* (*see* Appendix A for a listing of 22 CIRP group cases)

Dear Ms. Goron,

The Provider Reimbursement Review Board ("PRRB or Board") has reviewed the Parties comments regarding the Board's proposed Own Motion Expedited Judicial Review ("EJR") in the above referenced twenty-two (22) common issue related party ("CIRP") groups. The Board's decision determining that EJR is appropriate for the issue and federal fiscal years ("FFYs") under appeal in these 22 CIRP group cases is set forth below.

Background:

On August 5, 2021, the Board sent the Providers, in the above-captioned 22 CIRP group cases in Appendix A, a Request for Status Update and Notice of Potential Own Motion EJR letter asking the Providers for a status update and for the parties to file comments (for the cases that will remain open) regarding whether EJR is appropriate for the issue under appeal. On August 10, 2021, the Providers confirmed that they remained committed to pursuing the issue and concurred that cases on Appendix A are fully formed and complete.[1]

On September 1, 2021, the Medicare Contractor filed a response to the Board's Notice of Potential Own Motion EJR stating that it agreed that EJR is appropriate. *On September 7, 2021*, the Providers filed a response to the Board's Notice of Potential Own Motion EJR stating that it also agreed that EJR is appropriate. However, the Providers requested that the Board not issue EJR on its own motion but rather place the appeal on hold until after the Supreme Court issues its decision in *American Hosp. Ass'n v. Becera*, U.S. No. 20-1113 ("*AHA v. Becerra*"). The Providers asserted that the U.S. Supreme Court has requested briefing on the judicial preclusion provision at issue and its ruling may shed light on how broadly or narrowly courts should construe such provisions in light of the general presumption in favor of judicial review.

[1] The Board's notice of potential own-motion EJR also included two ***optional*** group appeals under Case Nos. 20-1176G and 21-1129G. These two optional groups are not reflected in Appendix A because the Board will issue correspondence on those appeals under separate cover. Accordingly, this decision will only cover the 22 CIRP group appeals listed in Appendix A.

However, the Providers assertion that, as of September 7, 2021, *AHA v. Becerra* is *currently* pending before the U.S. Supreme Court as of September 7, 2021 is incorrect. The Board notes that, on June 28, 2021, the U.S. Supreme Court ***denied*** AHA's petition for *certiorari* and, shortly thereafter, on August 23, 2021, ***denied*** a petition for rehearing. Accordingly, to the extent the Providers' request for abeyance may have had *any* basis, that basis is not gone and the Providers' request for abeyance is clearly unwarranted and moot.[2]

Issue in Dispute:

The Providers are challenging:

> Whether CMS acted unlawfully in refusing to restore the 0.7% payment cut in FFYs 2020 and 2021. Since CMS is treating this 0.7 reduction as permanent, it affects not only 2020 and 2021 reimbursement, but each subsequent year as well.[3]

Statutory and Regulatory Background:

In the federal year ("FY") 2008 inpatient prospective payment system ("IPPS") final rule,[4] the Secretary[5] adopted the Medicare severity diagnosis-related group ("MS–DRG") patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The Secretary believes that, by increasing the number of MS–DRGs and more fully taking into account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs will encourage hospitals to improve their documentation and coding of patient diagnoses.[6]

In the FY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FY 2008, -1.8 percent for FY 2009, and -1.8 percent for FY 2010.[7]

[2] The U.S. Supreme Court docket for *AHA v. Becerra* under Case No. 20-1113 is available at: https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/20-1113.html.
[3] Providers' Statement of the Issue at 1.
[4] 72 Fed. Reg. 47130, 47140 through 47189 (Aug. 22, 2007)
[5] of the Department of Health and Human Services.
[6] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).
[7] *See* 82 Fed. Reg. 37990, 38008 (Aug. 17, 2017).

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 ("TMA").[8] TMA § 7(a) reduced the documentation and coding adjustment made as a result of the MS–DRG system that the Secretary adopted in the FY 2008 IPPS final rule to -0.6 percent for FY 2008 and -0.9 percent for FY 2009.[9]

The Secretary implemented a series of adjustments required under TMA §§ 7(b)(1)(A) and 7(b)(1)(B) based on a retrospective review of FY 2008 and FY 2009 claims data. The Secretary completed these adjustments in FY 2013. However, the Secretary commented in the FY 2013 IPPS final rule that delaying full implementation of the adjustment required under TMA § 7(b)(1)(A) until FY 2013 had resulted in payments in FY 2010 through FY 2012 being overstated, and that these overpayments could not be recovered.[10]

Congress revisited TMA § 7(b)(1)(B) as part of the American Taxpayer Relief Act of 2012 ("ATRA").[11] Specifically, ATRA § 631 amended TMA § 7(b)(1)(B) to add clause (ii) which required the Secretary to make a recoupment adjustment or adjustments totaling $11 billion for discharges occurring during FYs 2014 to 2017. Per the revisions made by ATRA § 631(b), this adjustment "represents the amount of the increase in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied" (*i.e.*, represents the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under TMA § 7(b)(1)(A) until FY 2013).[12] As discussed above, this delay in implementing TMA § 7(b)(1) resulted in overstated payment rates in FYs 2010, 2011, and 2012 and the resulting overpayments could not have been recovered under the original TMA § 7(b).

The adjustment required under ATRA § 631 was a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, the Secretary "anticipated that any adjustment made to reduce payment rates in one year would eventually be offset by a positive adjustment in FY 2018, once the necessary amount of overpayment was recovered."[13]

However, Congress again stepped in to revise TMA § 7(b)(1)(B). First, in § 414 of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Congress revised TMA § 7(b)(1)(B) to add clause (iii) which replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023.[14] Second, in § 15005 of the 21st Century Cures Act ("21-CCA"),[15] Congress amended the MACRA revision in TMA § 7(b)(1)(B)(iii) by reducing the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points.[16]

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[8] Pub. L. 110–90, 121 Stat. 984 (2007).
[9] *Id.* at 986.
[10] *See* 82 Fed. Reg. at 38008.
[11] Pub. L. 112-240, 126 Stat. 2313 (2013).
[12] *Id.* at 2353.
[13] 82 Fed. Reg. at 38008.
[14] Pub. L. 114–10, § 414, 129 Stat. 87, 162-163 (2015).
[15] Pub. L. 114–255, 130 Stat. 1033 (2016).
[16] *Id.* at 1319-1320. *See also* 82 Fed. Reg. at 38008.

The Secretary's "actuaries estimated that a -9.3 percentage point adjustment to the standardized amount would be necessary if CMS were to fully recover the $11 billion recoupment required by [ATRA § 631] in FY 2014." Consistent with the policies that the Secretary has adopted in many similar situations, the Secretary implemented a phased in approach. For the first year, FY 2014, he implemented a -0.8 percentage point recoupment adjustment to the standardized amount. The Secretary declined, at that time, to set specific adjustments for FYs 2015, 2016, or 2017 "[a]s estimates of any future adjustments are subject to variations in total savings[.]"[17] However, he did estimate that, if adjustments of -0.8 percentage point were implemented in FYs 2014, 2015, 2016, and 2017, using standard inflation factors, then the requisite $11 billion would be recouped by the end of the statutory 4-year timeline.[18]

Consistent with the approach discussed in the FY 2014 rulemaking for recouping the $11 billion required by ATRA § 631, in the FY 2015 IPPS/LTCH PPS final rule[19] and the FY 2016 IPPS/LTCH PPS final rule,[20] the Secretary implemented additional -0.8 percentage point recoupment adjustments to the standardized amount in FY 2015 and FY 2016, respectively. The Secretary estimated that these adjustments, combined with leaving the prior -0.8 percentage point adjustments in place, would recover up to $2 billion in FY 2015 and another $3 billion in FY 2016. When combined with the approximately $1 billion adjustment made in FY 2014, the Secretary estimated that approximately $5 to $6 billion would be left to recover under ATRA § 631 by the end of FY 2016.

In the FY 2017 IPPS/LTCH PPS proposed rule,[21] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under ATRA § 631. For the FY 2017 IPPS/LTCH PPS final rule,[22] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FY 2014 through FY 2017 without exceeding this amount is -1.5 percentage points. Based on those updated estimates by the Office of the Actuary, the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under ATRA § 631.[23]

Once the recoupment required under ATRA § 631 was complete, the Secretary anticipated making a single positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631. However, MACRA § 414 (which was enacted on April 16, 2015) replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. In the FY 2017 rulemaking, the Secretary indicated that he would address the adjustments for FY 2018 and later fiscal years in future rulemaking. As noted previously, 21-CCA § 15005, which was enacted on

[17] 82 Fed. Reg. at 38008.
[18] *Id.*
[19] 79 Fed. Reg. 49853, 49874 (Aug. 22, 2014).
[11] 80 Fed. Reg. 49326, 49345 (Aug. 17, 2015).
[21] 81 Fed. Reg. 24946, 24966 (Apr. 27, 2016)
[22] 81 Fed. Reg. 56761 (Aug. 22, 2016).
[23] *Id.* at 56785.

December 13, 2016, amended TMA § 7(b)(1)(B) (as amended by ATRA § 631 and MACRA § 414) to reduce the adjustment for FY 2018 from a 0.5 percentage point to a 0.4588 percentage point. The Secretary believes the directive under 21-CCA § 15005 is clear and, as a result, in the FY 2018 IPPS/LTCH PPS proposed rule for FY 2018, the Secretary proposed to implement the required +0.4588 percentage point as a permanent adjustment to the standardized amount.[24]

A. The Final IPPS Rule for FY 2018

In response to the +0.4588 percentage point adjustment, several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FY 2017 under ATRA § 631, which exceeded the estimated adjustment of approximately -0.8 percentage point described in the FY 2014 IPPS/LTCH PPS rulemaking. Commenters contended that, as a result, hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA. They asserted that CMS' proposal to apply a 0.4588 percent positive adjustment for FY 2018 misinterprets the relevant statutory authority, and urged the Secretary to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FY 2018 (*i.e.*, the difference between the -1.5 percentage point adjustment made in FY 2017 and the initial estimate of -0.8 percentage point discussed in the FY 2014 IPPS/LTCH PPS rulemaking). The commenters also urged the Secretary to use his discretion under 42 U.S.C. § 1395ww(d)(5)(I) to increase the FY 2018 adjustment by 0.7 percentage point. Other commenters requested that, despite current law, CMS ensure that adjustments totaling the full 3.9 percentage points withheld under ATRA § 631 be returned.[25]

The Secretary responded by stating that, as discussed in the FY 2017 IPPS/LTCH PPS final rule,[26] CMS had completed the $11 billion recoupment required under ATRA § 631. The Secretary also continued to disagree with commenters who asserted that MACRA § 414 was intended to augment or limit the separate obligation under the ATRA to fully offset $11 billion by FY 2017.[27] Moreover, the Secretary pointed out in the FY 2018 IPPS/LTCH PPS proposed rule, he believes that the directive regarding the applicable adjustment for FY 2018 is clear. While the Secretary had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 requires that he not make the single positive adjustment he intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. The Secretary pointed out that, as noted by the commenters and discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage point adjustment originally estimated in the FY 2014 IPPS/LTCH PPS final rule.[28] Finally, the Secretary notes that 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and that this change was enacted on December 13, 2016, ***after*** CMS had proposed and

[24] 82 Fed. Reg. at 38009.
[25] *Id.*
[26] 81 Fed. Reg. 56783-85.
[27] *Id.* at 56784.
[28] 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013).

finalized the -1.5 percentage point adjustment as the final adjustment required under ATRA § 631 in the FY 2017 rulemaking. The Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under 21-CCA § 15005.[29]

B. The FY 2019 Adjustment to the Standardized Amount

In the Final Inpatient PPS Rule for FY 2019,[30] the Secretary finalized a +0.5 percentage point adjustment to the standardized amount for FY 2019, as required under MACRA § 414.

In the final IPPS rule, several commenters argued that the Secretary misinterpreted the Congressional directives regarding the level of positive adjustment required for FY 2018 and FY 2019. The commenters contended that, while the positive adjustments required under MACRA § 414 would only total 3.0 percentage points by FY 2023, the levels of these adjustments were determined using an estimated positive ''3.2 percent baseline'' adjustment that otherwise would have been made in FY 2018. The commenters believed that, because CMS implemented an adjustment of -1.5 percentage points instead of the expected -0.8 percentage points in FY 2017, totaling -3.9 percentage points overall, the Secretary has imposed a permanent -0.7 percentage point negative adjustment beyond its statutory authority, contravening what the commenters contend was Congress' clear instructions and intent. The commenters requested that the Secretary reverse his previous position and implement additional 0.7 percentage point adjustments for both FY 2018 and FY 2019. Some of the commenters requested that the Secretary use his statutory discretion to ensure that all 3.9 percentage points in negative adjustment be restored. In addition, some of the commenters acknowledged that CMS may be bound by law but expressed opposition to the permanent reductions and requested that the Secretary refrain from making any additional coding adjustments in the future.[31]

The Secretary responded by stating that, as discussed in the FY 2019 IPPS/LTCH PPS proposed rule, he believes MACRA § 414 and 21-CCA § 15005 clearly set forth the levels of positive adjustments for FYs 2018 through 2023. He was not convinced that the adjustments prescribed by MACRA were predicated on a specific ''baseline'' adjustment level. While he had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 required that a 0.5 percentage point positive adjustment be implemented for each of FYs 2018 through 2023, rather than the single positive adjustment he had anticipated making in FY 2018. As discussed in the FY 2017 IPPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage points adjustment originally estimated in the FY 2014 IPPS final rule.[32]Moreover, as discussed in the FY 2018 IPPS final rule, 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and this adjustment was enacted on December 13, 2016, ***after*** the Secretary had proposed and finalized the final negative -1.5 percentage points adjustment required under ATRA § 631. The Secretary does not believe that Congress enacted these adjustments with the

[29] 82 Fed. Reg. at 38009.
[30] 83 Fed. Reg. 41144 (Aug. 17, 2018).
[31] *Id.* at 41157.
[32] 78 Fed. Reg. at 50515.

intent that there would be an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017.[33]

C. The FY 2020 and FY 2021 Adjustments to the Standardized Amount

In both the FY 2020 IPPS Final Rule and the FY 2021 IPPS Final Rule, the Secretary adopted only a +.5 percent adjustment. In this regard, the Secretary stated the following in the preamble to the FY 2020 IPPS Final Rule:

> In the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19170 through 19171) consistent with the requirements of section 414 of the MACRA, we proposed to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2020. We indicated that this would constitute a permanent adjustment to payment rates. We stated in the proposed rule that we plan to propose future adjustments required under section 414 of the MACRA for FYs 2021 through 2023 in future rulemaking.
>
> ***
>
> As we discussed in the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19170 through 19171), and in response to similar comments in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41157), we believe section 414 of the MACRA and section 15005 of the 21st Century Cures Act set forth the levels of positive adjustments for FYs 2018 through 2023. We are not convinced that the adjustments prescribed by MACRA were predicated on a specific adjustment level estimated or implemented by CMS in previous rulemaking. While we had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA, section 414 of the MACRA required that we implement a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023, and not the single positive adjustment we intended to make in FY 2018. As discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, section 414 of the MACRA would not fully restore even the 3.2 percentage point adjustment originally estimated by CMS in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50515). Moreover, as discussed in the FY 2018 IPPS/LTCH PPS final rule, Public Law 114–255, which further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point, was enacted on December 13, 2016, after CMS had proposed and

[33] 83 Fed. Reg. at 41157.

> finalized the final negative -1.5 percentage point adjustment required under section 631 of the ATRA. We see no evidence that Congress enacted these adjustments with the intent that CMS would make an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017, nor are we persuaded that it would be appropriate to use the Secretary's exceptions and adjustments authority under section 1886(d)(5)(I) of the Act to adjust payments in FY 2020 to restore any additional amount of the original 3.9 percentage point reduction, given Congress' prescriptive adjustment levels under section 414 of the MACRA and section 15005 of the 21st Century Cures Act.
>
> After consideration of the public comments we received, we are finalizing our proposal to implement a 0.5 percentage point adjustment to the standardized amount for FY 2020.[34]

Similarly, in the preamble to the FY 2021 IPPS Final Rule, the Secretary stated:

> Consistent with the requirements of section 414 of the MACRA, we proposed to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2021. We indicated that this would constitute a permanent adjustment to payment rates. We stated in the proposed rule that we plan to propose future adjustments required under section 414 of the MACRA for FYs 2022 through 2023 in future rulemaking.
>
> ***
>
> : As we discussed in the FY 2021 IPPS/LTCH PPS proposed rule (85 FR 32471), and in response to similar comments in the FY 2020 IPPS/LTCH PPS final rule (84 FR 42057), we believe section 414 of the MACRA and section 15005 of the 21st Century Cures Act set forth the levels of positive adjustments for FYs 2018 through 2023. We are not convinced that the adjustments prescribed by MACRA were predicated on a specific adjustment level estimated or implemented by CMS in previous rulemaking. While we had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA, section 414 of the MACRA required that we implement a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023, and not the single positive adjustment we intended to make in FY 2018. As discussed in the FY 2017

[34] 84 Fed. Reg. 42044, 42057 (Aug. 16, 2019).

> IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, section 414 of the MACRA would not fully restore even the 3.2 percentage point adjustment originally estimated by CMS in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50515). Moreover, as discussed in the FY 2018 IPPS/LTCH PPS final rule, Public Law 114–255, which further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point, was enacted on December 13, 2016, after CMS had proposed and finalized the final negative -1.5 percentage point adjustment required under section 631 of the ATRA. We see no evidence that Congress enacted these adjustments with the intent that CMS would make an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017, nor are we persuaded that it would be appropriate to use the Secretary's exceptions and adjustments authority under section 1886(d)(5)(I) of the Act to adjust payments in FY 2021 to restore any additional amount of the original 3.9 percentage point reduction, given Congress' prescriptive adjustment levels under section 414 of the MACRA and section 15005 of the 21st Century Cures Act. We intend to address adjustments for FY 2022 and later years in future rulemaking.
>
> After consideration of the public comments we received, we are finalizing our proposal to implement a 0.5 percentage point adjustment to the standardized amount for FY 2021.[35]

<u>Providers' Position and Comments on EJR</u>:

The Providers contend CMS acted unlawfully by failing to restore the 0.7 percent reduction through a 0.7 percent positive adjustment to the IPPS rates in 2020 and 2021. The Providers argue as a result CMS is recouping from providers more than the $11 billion authorized by ATRA. The Providers maintain CMS is statutorily required to make a curative adjustment. The TMA, Abstinence Education and QI Programs Extension Act of 2007 ("TMA") provides that any downward adjustment made pursuant to ATRA must not be reflected in later years. The Providers assert CMS itself recognized that the adjustment required under ATRA is a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. The Providers argue nothing that occurred in subsequent legislative amendments changes that fact. CMS' failure to comply with this statutory directive to restore any reduction (absent explicit subsequent instructions) is therefore unlawful.

The Providers assert at a minimum CMS has the discretion to restore this cut under its power to implement exceptions and adjustments to such payment amounts as the Secretary deems

[35] 85 Fed. Reg. 58432, 58444-45 (Sept. 18, 2020).

appropriate. The Providers argue CMS has committed reversible error in stating in the IPPS Final Rules for FFYs 2020 and 2021 that it did not have the authority to make this curative adjustment. The Providers maintain not only is CMS' error regarding its own authority reason enough to remand the issue to CMS for further consideration, CMS' failure to act on its authority to restore the act is arbitrary and capricious since there is no reasonable basis for maintaining this reduction after the required recoupment has been achieved.[36]

The Providers agree that it is appropriate that the Board grant EJR over the group appeals as the Board has jurisdiction over the appeals, the 0.7 payment reduction is set forth in rulemakings, and the Board does not have the authority to grant the relief sought.[37]

<u>Medicare Contractor's Response to EJR</u>:

The Medicare Contractor states that although the provider has not explained how they believe the case will proceed in light of the decision in the DC Circuit court, they agree if they are intending to challenge the reduction, that EJR is appropriate.

<u>Decision of the Board</u>:

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

A. Jurisdiction

As previously noted, all of the participants in the above-captioned CIRP group appeals appealed from the FFYs 2020 and 2021 IPPS final rules and were directly added to the groups. The Board notes that each of these 22 CIRP groups is fully formed and, as such, pursuant to 42 C.F.R. § 405.1837(e)(1):

> When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, ***no other provider*** *under common ownership or control may appeal to the Board the issue that is the subject of the group appeal* with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.[38]

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[36] Providers' Statement of the Issue at 2.
[37] Providers' ATRA EJR Response at 2.
[38] (Emphasis added.)

The Board has determined that the participants documentation for each CIRP group shows that the estimated amount in controversy exceeds $50,000, as required for group appeals, and that the participants each filed timely appeals. Based on the above, the Board finds that it has jurisdiction for the above-referenced CIRP group appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount in each case.

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

The Board notes that the cost reporting periods for the participants in these group appeals that are impacted by the FFYs 2020 and 2021 IPPS final rules began well after January 1, 2016, and as such, are subject to the newly added 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports.[39] However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether any Provider's cost report included an appropriate claim for the specific item under appeal, presumably because any such potential issue is not yet ripe. In this regard, the Board notes that the participants are appealing the FFYs 2020 and 2021 Federal Register Notices 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.[40]

C. Analysis Regarding Appealed Issue

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply with the 0.7 percent reduction to the IPPS standard amount for FFYs 2020 and 2021 as published in the FY 2020 and 2021 IPPS Final Rules on August 16, 2019, and September 18, 2020, because CMS clearly intended to bind all hospitals, which are subject to IPPS, to this payment reduction, and as such, they are uncodified regulations adopted through the Federal Register rulemaking process. Accordingly, the Board concludes that it lacks the authority to grant the relief sought by the Providers to reverse or otherwise invalidate the negative adjustment of 0.7 percent to the IPPS standard amount for FYs 2020 and 2021 as published in the FYs 2020 and 2021 IPPS Final Rules. Consequently, the Board hereby grants EJR for the issue and FFYs under dispute. The Providers' request to place the appeal on hold until after the U.S. Supreme Court issues its decision in *AHA v. Becerra* is denied because, as discussed above, the U.S. Supreme Court has denied AHA's petition for review rendering any potential basis for the Providers' request moot and unwarranted.

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in these 22 CIRP group appeals are entitled to a hearing before the Board;

[39] *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015).
[40] *See* 80 Fed. Reg. at 70556, 70569-70.

2) Based upon the participants' assertions regarding the 0.7 percent reduction to the IPPS standardized amount, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the 0.7 percent reduction to the FYs 2020 and 2021 IPPS standardized amount as published in the FYs 2020 and 2021 IPPS Final Rules is valid.

Accordingly, the Board finds that the question of the validity of the 0.7 percent reduction to the FYs 2020 and 2021 IPPS rates as published in the FYs 2020 and 2021 IPPS Final Rules properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby find that EJR is appropriate for the issue and the subject years in the above-captioned 22 CIRP group cases. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby close the 22 CIRP group cases.

Board Members Participating:

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

FOR THE BOARD:

9/27/2021

Clayton J. Nix, Esq.
Chair
Signed by: PIV

Enclosures: Schedule of Providers

cc: Judith Cummings, CGS Administrators
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Bill Tisdale, Novitas Solutions, Inc.
Danelle Decker, National Government Services, Inc.
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Notice of Dismissal***
Rush University Medical Center (Prov. No. 14-0119)
FYE 6/30/2008
PRRB Case No. 13-3456

Dear Mr. Johnston and Ms. Hartley:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed Rush University Medical Center's ("Rush" or "Provider") appeal following the Board's November 17, 2020 Remand Letter concerning Rush's Medicare Part C Days issue[1] and the Board's December 31, 2020 Jurisdictional Decision.[2] Following review, the Board notes that only one issue remains within the instant appeal, Issue 6, Bad Debts—Collection Agency Procedures.[3] Further, the Provider Representative advised the Board in its letter dated August 24, 2020 that the parties were actively involved in discussions to potentially administratively resolve this Issue.

In light of the foregoing, the Board issued a Request for Supplemental Information on June 4, 2021. However, the Board has received no further update from the parties regarding the status of this case.

Issue in Dispute

Within its Request for Hearing ("RFH"), Rush describes its legal basis for the Bad Debts issue in the following manner:

> The [Medicare Contractor] disallowed a portion of the bad debt expense claimed on the basis that the Provider had not sufficiently exhausted collection procedures. The

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[1] Pursuant to the mandates contained within CMS Ruling, CMS-1739-R.

[2] Within the Jurisdictional Decision, the Board found that it lacked jurisdiction to consider Rush's GME-FTE Adjustments issue (Issue 3) and its GME-Base Year FTE Cap Adjustments issue (Issue 4), thus dismissed these issues from the instant appeal.

[3] Rush's September 3, 2013 Appeal Request originally contained 9 issues. Prior to the Board issuing its November 17, 2020 Remand Order, Rush withdrew the following five issues at differing points in time not relevant to the instant request: Rural Floor Budget Neutrality (Issue 8), DSH SSI Percentage (Issue 1), IME-Research Rotations (Issue 2), Effect of Prior Year Adjustments (Issue 9), and IME-Current Year Rotation Adjustments (Issue 7).

> Provider believes this finding is in error and is not supported by the applicable regulation, 42 C.F.R. § 413.89.[4]

In its Final Position Paper, Rush explains that it turned certain patient accounts over to an outside collection agency, but that they were "actually uncollectible" and "worthless" within the meaning of 42 C.F.R. § 413.89(e) and could be claimed as Medicare bad debts.[5] Likewise, Rush states that the criteria found in PRM 15-1 § 310.2, which mirrors § 413.89(e), were met.[6] The Provider notes the Medicare Contractor's position that these bad debts were not allowable in the instant appeal for FY 2008 because they were still being pursued until FY 2010, when they were returned to Rush by the outside collection agency.[7] While Rush disagreed with this assessment, it claimed it would be open to resolving the instant appeal by having the bad debts included in a revised NPR for FY 2010.[8]

Revisions to 42 C.F.R. § 413.89(e)

In September, 2020, the Secretary published a Final Rule finalizing a number of amendments to 42 C.F.R. § 413.89(e), arguing these amendments clarified and codified several longstanding collection policies with regard to bad debts. Specifically, the Secretary explained

> that to be allowable, a bad debt must be "actually uncollectible when claimed as worthless," and also that "sound business judgment established that there was no likelihood of recovery at any time in the future." § 413.89(e)(3) and (4). It has been our longstanding policy that an account that remains at a collection agency has satisfied neither of these regulatory conditions, remains in a collection effort status, and thus cannot be claimed as a Medicare bad debt. An account that remains at a collection agency still holds some value for the chance of a recovery and there is a possibility, a likelihood, of recovery while the account remains there.[9]

Among other revisions, and relevant to this case, 42 C.F.R. § 413.89(e) (2020) was amended to include the following language when collecting bad debts from non-indigent beneficiaries:

> (B) A provider that uses a collection agency to perform its collection effort must do all of the following:
>
> . . . .

---

[4] RFH TAB 3 at unnumbered page 3.
[5] Provider's Final Position Paper at 15 (May 8, 2019).
[6] *Id.* at 16 (also citing *Foothill Hosp. – Morris L. Johnston Memorial v. Leavitt*, 558 F. Supp. 2d 1 (D.C. Cir. 2008); *Dist. Hosp. Partners v. Sebelius*, 932 F. Supp. 2d 194 (D.D.C. 2013)).
[7] *Id.* at 17-18.
[8] *Id.* at 18.
[9] 85 Fed. Reg. 58432, 58995-58996 (Sept. 18, 2020).

> (3) Before claiming the unpaid amounts as a Medicare bad debt, cease all collection efforts, including the collection agency efforts, and ensure that the collection accounts have been returned to the provider from the agency.

Since the Secretary claimed this amendment merely clarified and codified longstanding CMS policy, she specifically made it retroactive and effective to cost reporting periods beginning before, on, and after the effective date of the Final Rule.[10]

The Board recognizes that the cases cited[11] by the Provider may contradict the amended regulations at 42 C.F.R. § 413.89, but these decisions, as well as the Final Position Papers filed by the parties, predate the amended regulations. As a result, and since the Board is generally bound to apply the provisions of Title XVIII of the Social Security Act and the regulations thereunder,[12] the Board requested that the Provider supplement its Final Position Paper with regard to the impact of this new regulation on its arguments and/or request for relief in a Request for Supplemental Information dated June 14, 2021.

The Board requested that the Provider submit a supplemental brief **within thirty (30) days of that letter's signature date** to address the amended regulations (*i.e.*, July 14, 2021). The Medicare Contractor's responsive supplemental brief was due thirty (30) days following the date on which the Provider filed its supplemental brief. **The Board specifically noted that these filing deadlines were firm and that the Board was specifically exempting them from the Alert 19 suspension of Board filing deadlines**. On August 13, 2021, Board Staff contacted the parties to confirm that no Supplemental Briefs had been filed. To date, the Board has received no response from the Provider to its Request for Supplemental Information or the Board Staff's August 13, 2021 inquiry.

Board Rule 41.2 (Aug. 29, 2018) permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- **upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868)**,
- **if the Board is unable to contact the provider or representative at the last known address**, or
- upon failure to appear for a scheduled hearing.

Further, Board Rule 5.2 addressed the Representative's responsibilities:

> *The representative is responsible for ensuring his or her contact information is current with the Board*, including a current email address and phone number. The case representative is also responsible for meeting

[10] *Id.* at 58995.
[11] *See supra* n.6.
[12] 42 C.F.R. § 405.1867.

> the Board's deadlines and for timely responding to correspondence or requests from the Board or the opposing party.
>
> Failure of a representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings

Failure to comply with the Board's deadline for submission of a required filing can be found at 42 C.F.R. § 405.1868:

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

Finally, the regulations governing position papers can be found at 42 C.F.R. § 405.1853:

> (b) Position papers. (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. **In each case, *and as appropriate*, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board**.[13]
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (as described in §405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.

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[13] (Emphasis added.)

Board Decision:

The Board finds that the Provider has failed to comply with the Board's procedures, specifically the filing deadlines set in this case and, further, that it has been unable to contact the provider or representative at the last known address. As such, the Board hereby deems this case abandoned, closes it and removes it from the Board docket.

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

Board Members Participating:

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

For the Board:

9/28/2021

X Robert A. Evarts, Esq.

Robert A. Evarts, Esq.
Board Member
Signed by: Robert A. Evarts -A

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Determination***
Stanford Health Care - Valleycare (Prov. No. 05-0283)
FYE 8/31/2017
Case No. 21-1594

Dear Ms. Ellis and Ms. Frewert:

The Provider Reimbursement Review Board ("Board") has reviewed the subject individual appeal filed by Toyon Associates, Inc. ("Toyon" or "Representative") subsequent to a review of the same Provider's participation in two optional group appeals from the same determination. The pertinent facts with regard to the Provider's appeal and the jurisdictional determination of the Board, are set forth below.

Pertinent Facts

On August 17, 2021, Toyon filed a request to establish an individual appeal under Case No. 21-1594 for Stanford Health Care - Valleycare (05-0283) ("Valleycare" or "Provider") for calendar year ("CY") 8/31/2017. The individual appeal includes two issues: DSH Accuracy of CMS Developed SSI Ratio and DSH Inclusion of Medicare Part C Days in the SSI Ratio.

The appeal was filed from a Notice of Corrected Reimbursement issued as a result of the Provider's request for realignment.[1]

Based on a review of the supporting documentation, it is noted that:

- On July 27, 2020, Toyon requested a Reopening for Valleycare "request[ing] a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year." This reopening request was made "pursuant to 42 CFR 412.106(b)(3)" which is the regulation governing requests to realign the SSI ratio (as used in the DSH adjustment calculation) from the federal fiscal year to a provider's fiscal year.

[1] Valleycare's final determination from which it is appealing is titled "Notice of Corrected Reimbursement," referred to hereinafter as "RNPR."

- On August 6, 2020, the MAC issued the Notice of Reopening "To adjust the SSI ratio used to calculate the Provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period *rather than the federal fiscal year*.[2]

- On February 18, 2021, the Medicare Contractor issued the RNPR.

- The adjustments being appealed from the RNPR are Audit Adjustment Nos. 4, 9, 19-21. Adjustment 20 adjusted the SSI Percentage from 5.92 to 5.99 based on the realignment. The other adjustments affected the recalculation of the DSH percentage.

Valleycare's Direct Add Requests to optional groups:

On February 6, 2020, Toyon established an *optional* group under Case No. 20-0956G entitled the "Toyon Associates CY 2017 Accuracy of CMS Developed SSI Ratio Group." On November 4, 2020, Toyon transferred Valleycare's SSI Accuracy issue from its individual appeal, Case No. 20-1538 into the *optional* group.[3]

On September 9, 2020, Toyon established an *optional* group under Case No. 20-2047G entitled the "Toyon Associates CY 2017 DSH Medicare Part C - SSI Ratio/DE Part C - Medicaid Ratio Group." On November 4, 2020, Toyon also transferred the Part C Days issue from Valleycare's individual appeal into the *optional* group.

On August 4, 2021, Toyon filed a request (which was supplemented on August 6, 2021) for Valleycare to be ***directly added*** to the two optional groups from receipt of its February 18, 2021 RNPR.[4]

Board's Determination:

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

The 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

[2] (Emphasis added.)
[3] The individual appeal was filed from receipt of the original Notice of Program Reimbursement ("NPR") dated October 10, 2019.
[4] In the Direct Add Requests, Toyon referenced the Provider as "Valley Memorial Hospital."

> 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.

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider ... has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **<u>Exception</u>**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[5]

[5] (Emphasis added.)

Accordingly, pursuant to 42 C.F.R. § 405.1889(b) (and § 405.1835(a)(1) which references that regulation), the Board has jurisdiction only over those matters that have been "specifically revised" in a revised determination. More specifically, 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[.]"[6]

Here, the Board finds that it does not have jurisdiction over the SSI Accuracy and Medicare Part C Days issues for Valleycare (05-0283) appealed from the RNPR because the RNPR was issued as a result of the Provider's SSI Realignment request, and did not adjust either of the two issues under appeal in this individual appeal. As a result, the Provider does not have the right to appeal this determination under 42 C.F.R. § 405.1889(b) as referenced in §405.1835(a)(1).

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

> (2) *First computation: Federal fiscal year*. **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -
> (i) Determines the number of patient days that –
> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[7]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[8] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

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

[6] 42 C.F.R. § 405.1889(b)(1).
[7] (Emphasis Added.)
[8] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).

412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years thatspanned the hospital's cost reporting period***."[9]

2. 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005).—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether ornot it is a more favorable number than the DSH percentage based on the Federal fiscal year. . . .*

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year.* The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[10]

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

Since the only matter specifically revised in the RNPR was an adjustment related to realigning the SSI percentage from the Federal fiscal year to the hospital's fiscal year, the Provider (Vallyecare) does not have a right to appeal the SSI Accuracy or Medicare Part C Days issues under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1). The Board hereby closes Case No. 21-1594 and removes it from the docket. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[11]

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[9] (Emphasis Added.)

[10] (Emphasis Added.)

[11] *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).

The Board determination with regard to whether it will grant the Provider's request to join fully formed groups, Case Nos. 20-0956G and 20-2047G, will be issued under separate cover.[12] (Indeed, the Provider has already ***previously*** appealed these two issues *from its* ***original*** *NPR* where: (a) it was transferred to Case No. 20-0956G for the SSI Accuracy Issue; and (b) it was transferred Case No. 20-2047G. The Provider is still an active participant in both optional groups based on the *original NPR* appeal.)

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.

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

For the Board:

9/29/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

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

[12] The Provider filed requests to be directly added to the two existing fully formed optional groups (Case Nos. 20-0956G & 20-2047G) 167 days after issuance of the RNPR. It appears that because a determination regarding the Direct Add requests had not been rendered, the Provider filed an individual appeal from the RNPR on the 180th day (prior to the expiration of its filing deadline),

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Via Electronic Delivery

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RE: ***Jurisdictional Determination***
Kern Medical Center (Prov. No. 05-0315)
FYE 6/30/2015
Case No. 21-1644

Dear Ms. Giberti and Ms. Frewert:

The Provider Reimbursement Review Board ("Board") has reviewed the subject individual appeal filed by Toyon Associates, Inc. ("Toyon" or "Representative") subsequent to a review of the same Provider's participation in two optional group appeals based on direct adds appealing from the same determination. The pertinent facts with regard to the Provider's appeal and the jurisdictional determination of the Board, are set forth below.

Pertinent Facts

On August 27, 2021, Toyon filed a request to establish an individual appeal under Case No. 21-1644 for Kern Medical Center (05-0315) ("Kern" or "Provider") for calendar year ("CY") 6/30/2015. The individual appeal includes two issues: DSH Accuracy of CMS Developed SSI Ratio and DSH Inclusion of Medicare Part C Days in the SSI Ratio.

The appeal was filed from a Notice of Corrected Reimbursement issued as a result of the Provider's request for realignment.[1]

Based on a review of the supporting documentation, it is noted that:

- On June 30, 2020, Toyon requested a Reopening for Kern "request[ing] a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year." This reopening request was made "pursuant to 42 CFR 412.106(b)(3)" which is the regulation governing requests to realign the SSI ratio (as used in the DSH adjustment calculation) from the federal fiscal year to a provider's fiscal year.

[1] Kern's final determination from which it is appealing is titled "Notice of Corrected Reimbursement," referred to hereinafter as "RNPR."

- On August 7, 2020, the MAC issued the Notice of Reopening "To adjust the SSI ratio used to calculate the Provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period *rather than the federal fiscal year*.[2]

- On March 1, 2021, the Medicare Contractor issued the RNPR.

- the adjustment being appealed from the RNPR is Audit Adjustment No. 5. Audit Adjustment No. 5 adjusted the SSI Percentage from 26.65 to 28.71 as a result of the realignment.

Kern's Direct Add Requests to optional groups:

On October 12, 2018, Toyon established an *optional* group under Case No. 19-0040G entitled the "Toyon Associates CY 2015 Accuracy of CMS Developed SSI Ratio Group." On July 5, 2019, Toyon transferred Kern's SSI Accuracy issue from its individual appeal, Case No. 19-0320 into the *optional* group.[3]

On June 7, 2019, Toyon established an optional group under Case No. 19-2021G entitled the "Toyon Associates CY 2015 DSH Medicare Part C - SSI Ratio/DE Part C - Medicaid Ratio Group." On July 5, 2019, Toyon also transferred the Part C Days issue from Kern's individual appeal into the *optional* group.

On August 20, 2021, Toyon filed a request for Kern to be directly added to the two optional groups from receipt of its March 1, 2021 RNPR.

Board's Determination:

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

The 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. . . .

[2] (Emphasis added.)
[3] The individual appeal was filed from receipt of the original Notice of Program Reimbursement ("NPR") dated May 22, 2018.

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.

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider ... has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **<u>Exception</u>**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[4]

Accordingly, pursuant to 42 C.F.R. § 405.1889(b) (and § 405.1835(a)(1) which references that regulation), the Board has jurisdiction only over those matters that have been "specifically revised" in a revised determination. More specifically, when a final determination is reopened

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[4] (Emphasis added.)

and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5]

Here, the Board finds that it does not have jurisdiction over the SSI Accuracy and Medicare Part C Days issues for Kern Medical Center (05-0315) appealed from the RNPR because the RNPR was issued as a result of the Provider's SSI Realignment request, and did not adjust either of the two issues under appeal in this individual appeal. As a result, the Provider does not have the right to appeal this determination under 42 C.F.R. § 405.1889(b) as referenced in §405.1835(a)(1).

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

> (2) *First computation: Federal fiscal year*. **For each month** of the Federal fiscal year in which the hospital's cost reporting period begins, CMS -
> (i) Determines the number of patient days that –
> (A) Are associated with discharges occurring **during each month**; and
>
> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[7] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

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

[5] 42 C.F.R. § 405.1889(b)(1).
[6] (Emphasis Added.)
[7] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).

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***."[8]

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

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***<u>months</u> included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[9]

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

Since the only matter specifically revised in the RNPR was an adjustment related to realigning the SSI percentage from the Federal fiscal year to the hospital's fiscal year, the Provider (Kern) does not have a right to appeal the SSI Accuracy or Medicare Part C Days issues under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1). Therefore, the Board dismisses Case No. 21-1644 and removes it from the docket. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[10]

The Board determination with regard to whether it will grant the Provider's request to join fully formed groups, Case Nos. 19-0040G and 19-2021G, will be issued under separate cover.[11]

---

[8] (Emphasis Added.)

[9] (Emphasis Added.)

[10] *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).

[11] The Provider filed requests to be directly added to the two existing fully formed optional groups (Case Nos. 19-0040G & 19-2021G) 172 days after issuance of the RNPR. It appears that, because a determination on the direct add requests filed from the RNPR had not yet been rendered, the individual appeal was filed from the same RNPR on the 179th day (prior to the expiration of the Provider's filing deadline).

(Indeed, the Provider has already ***previously*** appealed these two issues *from its* ***original*** *NPR* where: (a) it was transferred to Case No. 19-0040G for the SSI Accuracy Issue; and (b) it was transferred Case No. 19-2021G. The Provider is still an active participant in both optional groups based on the *original NPR* appeal.)

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:

9/29/2021

Clayton J. Nix, Esq.
Chair
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cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services, Inc.

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RE: *Jurisdictional Decision* – No Right to Appeal & Duplicate CIRP Group
LifePoint 2011 DSH Medicare/Medicaid Medicare Advantage Days CIRP Group
Case No. 14-1982GC

Dear Ms. Elias and Ms. Huggins:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in the common issue related party ("CIRP") group under Case No. 14-1982GC. The Board's decision is set forth below.

Background

The group representative filed a hearing request in this case with the Board on January 24, 2014.[1] On April 18, 2018, the Board agreed to consolidate Medicaid Fraction Pt C Days case (14-1984GC) into SSI Fraction Part C case (14-1982GC) after finding that the two groups included the same issue.

The group currently includes two (2) participants in this group that have appealed from revised NPRs that were issued subsequent to their requests for SSI realignment.

- Provider 20 – Southern Tennessee Medical Center (PN 44-0058, 12/31/2011)
    - Adj. No 1: "To adjust the SSI% and DSH% to audited amounts in accordance with PRM-2, Section 4030.1 and 42 CFR 412.106 (d)."
- Provider 25 – Palestine Regional Medical Center (PN 45-0747, 12/31/2011)
    - Adj. Nos. 4, 5: "To adjust the SSI percentage per CMS release;" and, "To adjust the allowable DSH percentage."

The Providers requested reopenings to realign their SSI percentages, on December 22, 2015, and December 14, 2015, respectively.[2]

Board's Analysis and Decision

[1] Providers' Request for Hearing (Jan. 24, 2014).
[2] *See* Provider's Request to Realign SSI percentage (Dec. 22, 2015); *Id.* (Dec. 14, 2015).

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), 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 ($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 revised NPR at 42 C.F.R. § 405.1885 (2014), 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 (2017)[3] explains the effect of a cost report revision:

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

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

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with

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

> respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[4]

As described below, the Board finds that it does not have jurisdiction over the Part C Days issue in this appeal for Southern Tennessee Medical Center and Palestine Regional Medical Center's revised NPR appeals, because the revised NPRs were issued as a result of the Providers' SSI Realignment requests, and did not make adjustments related to the Part C days issue.

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 percentages from the federal fiscal year end to their individual cost reporting fiscal year end. The audit adjustments associated with the revised NPRs under appeal clearly revised the SSI percentage in order to realign it from a federal fiscal year to the providers' respective fiscal year. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage.

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

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

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

> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[7] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[8]

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

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

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

> *to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[9]

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

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the revised NPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the RNPR appeal of the DSH Part C days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[10]

In conclusion, the Board is dismissing two participants, Participant No. 20 – Southern Tennessee Medical Center (PN 44-0058, 12/31/2011), and Participant No. 25 – Palestine Regional Medical Center (PN 45-0747, 12/31/2011) from this CIRP group because they do not have the right to appeal the revised NPRs at issue under 42 C.F.R. § 405.1889 for the DSH Part C days issue. The Board notes that both Providers also appealed the Part C days issue from original NPRs, which remain pending in the appeal. The remaining providers will be remanded pursuant to CMS Ruling 1739-R under separate cover.

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

<u>Board Members Participating</u>:

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For the Board:

9/29/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

---

[9] (Emphasis added.)
[10] *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).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Determination***
First EJR Request
14-1614GC Mercy Health 2010 Medicaid Fraction Dual Eligible Part A Days Group
14-4171GC Mercy Health 2011 Medicaid Fraction Dual Eligible Days Group
15-0388GC Mercy Health 2012 Medicaid Fraction Part A Days Group
15-3377GC Mercy Health 2013 No Part Part A Days
17-1132GC QRS Mercy Health Syst.2014 DSH Medicaid Fraction Dual Eligible Days Group
Second EJR Request
14-1613GC Mercy Health 2010 SSI Fraction Dual Eligible Days Group
14-4172GC Mercy Health 2011 SSI Fraction Dual Eligible Days Group
15-0387GC Mercy Health System 2012 SSI Fraction Part A Days Group
15-3376GC Mercy 2013 SSI Fraction Dual Eligible Days Group
Related Case Dismissal
17-1129GC Mercy Health Syst. 2014 DSH Medicaid Fraction Dual Eligible Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' October 30, 2020 request for expedited judicial review ("EJR") for the above-referenced common issue related party ("CIRP") group appeals.[1] The Board's determination regarding EJR is set forth below.

Effect of COVID -19 on Board Operations and Staying of the 30-day Period to Respond to EJR Requests:

By letter dated November 9, 2020, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for these five CIRP groups consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties "Temporary COVID-19 Adjustments to PRRB Processes." On April 9, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance

[1] The Providers' Schedules of Providers and associated jurisdictional documents were not file electronically until July 29, 2021.

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

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

Issue in Dispute:

The group issue statement filed to establish each of these 9 CIRP groups is identical. First, it is entitled "Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days) and contains the following description of the issue:

> Whether patient days associated with Medicare Part A and Title XIX patients should be *included* in the ***Medicaid*** percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have *included* in the ***Medicaid*** fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.[2]

The group issue statement then provides the following "Statement of the Legal Basis":

> The Provider contends that the MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.

---

[2] (Emphasis added.)

> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. *The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.*
>
> *It is the Provider's contention that these days must be included in the Medicaid percentage*.[3]

The EJR request characterizes the issue in these appeals as:

> Whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "*dual eligible*"), and for whom Medicare has not made payment for that inpatient stay (hereinafter referred to as *"noncovered days")* should be included in the *Medicare* fraction of the Medicare Disproportionate Share (DSH) adjustment, as alleged by the MAC [Medicare administrative contractor], or should be excluded *Medicare* fraction of the DSH adjustment, and instead included in the *Medicaid* fraction . . . .[4]

The EJR request specifies that the relief being requested is that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."[5]

[3] (Italics emphasis added and bold and underline emphasis in original.)
[4] Providers' EJR request at 2-3 (emphasis in original).
[5] *Id.* at 1.

Statutory and Regulatory Background

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system (“IPPS”).[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[8] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (“DPP”).[10] 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.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] 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 . . . .[13]

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.[14]

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[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(2)-(3).

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

> 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.[15]

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.[16]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[17] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[18]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[19] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[20] The Secretary then summarized its policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[21]

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[15] (Emphasis added.)
[16] 42 C.F.R. § 412.106(b)(4).
[17] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.* at 27207-27208.

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[22] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[23] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[24]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[25] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[26] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [27] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[28]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[29] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[30]

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[22] *Id.* at 27207-08.
[23] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[24] 68 Fed. Reg. at 27208.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[30] *Id.*

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[31]

In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[32]
>
> ****
>
> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[33]

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[34] In order to effectuate this policy change, the FY 2005

[31] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[32] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[33] *Id.* at 49099 (emphasis added).
[34] *Id.*

IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[35] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[36]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[37]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[38]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[39] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is

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[35] *See id.* at 49099, 49246.
[36] (Emphasis added.)
[37] (Emphasis added.)
[38] *Id.*
[39] 317 F. Supp. 3d 168 (D.D.C. 2018).

procedurally defective and arbitrary and capricious.[40] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[41] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[42] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[43] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[44] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[45] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[46]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[47] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[48] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[49] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate contest in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[50] and that the regulation is procedurally invalid.[51]

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[40] *Id.* at 172.
[41] *Id.* at 190.
[42] *Id.* at 194.
[43] *See* 2019 WL 668282.
[44] 718 F.3d 914 (2013).
[45] 657 F.3d 1 (D.C. Cir. 2011).
[46] 718 F.3d at 920.
[47] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[48] *Id.* at 1141.
[49] *Id.*
[50] *Id. at 1162.*
[51] *Id. at 1163*

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[52] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[53] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[54] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[55] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[56] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[57] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[58] Accordingly, the Ninth Circuit to the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force).

As of the date of this decision, the Secretary's position with respect to the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed. The U.S. Supreme Court granted the Secretary's petition for certiorari in *Becerra v. Empire Health Fund*, No. 20-1312, and that case is scheduled for oral argument on November 29, 2021.

Providers' Request for EJR

The Providers contend that the non-covered patient, *i.e.*, days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make payment for their hospital stays because the patient's Medicare patient days were exhausted or because a third

[52] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir., Oct. 20, 2020). It is unclear if the Secretary will petition the U.S. Supreme Court to review the Ninth Circuit's *Empire* decision.
[53] *Id.* at 884.
[54] *Id.* at 884.
[55] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[56] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[57] *Id.* at 886.
[58] *Id.*

party made payment, should be excluded from the Medicare fraction of the DSH fraction. The Providers maintain *in their EJR request* that these non-covered patient days should be treated consistently: (1) they should be included in both the numerator and denominator of the SSI fraction; or (2) excluded from the numerator and denominator of the SSI fraction and then be recognized in the numerator of the Medicaid fraction.[59]

The Providers explain that the applicable regulations require that non-covered patient days be included in the Medicare fraction due to the change made to the regulations effective October 1, 2004. This was accomplished by the deletion of the word "covered" where it had previously appeared in the definition of the Medicare fraction in 42 C.F.R. § 412.106(b)(2)(i). As a result of this change, the regulation now requires the inclusion in the Medicare fraction of both exhausted benefit and Medicare secondary payment days associated with patient discharges occurring on or after October 1, 2004.

The Providers assert that the Secretary *improperly promulgated* the revision to § 412.106(b)(2)(i) as part of the FY 2005 IPPS Final Rule and that this revision should be vacated due to ***procedural*** violations of the Administrative Procedures Act ("APA").[60] In support of its position, the Providers note that, in *Allina Health Servs. v. Sebelius* ("*Allina*"), the D.C. Circuit recently invalidated a different regulatory revision made in the same rulemaking.[61] In *Allina*, the D.C. Circuit vacated the Secretary's regulation requiring Part C days be included in the Medicare fraction where the Secretary's policy prior to October 1, 2004 was to exclude Part C days from the Medicare fraction. The D.C. Circuit concluded that the Part C days regulation was not a logical outgrowth of the proposed regulation and that the proposed rule was merely an indication that the Secretary was considering a clarification of existing policy rather a reversal of the existing policy.

The Providers put forward another challenge to the ***procedural*** validity of the revision to § 412.106(b)(2)(i) by arguing that the Secretary's FY 2005 regulations requiring inclusion of the non-covered days in the Medicare fraction were not the product of reasoned decision-making.[62] The Providers argue that the dual eligible days proposed rule as published in the FY 2004 IPPS proposed rule was equally misleading with respect to the Secretary's policy. As with the Secretary's Part C days policy, the Secretary adopted a policy with regard to dual eligible days that was the reverse of the proposed regulation and erroneously described the policy with respected to dual eligible days in the FY 2004 IPPS proposed rule. The Provider's contend that the convoluted nature of this rulemaking in which the Secretary both got her facts mixed up while at the same time shifting positions could only create among the public the type of hopeless confusion which the D.C. Circuit found in *Allina.*[63]

Accordingly, the Providers maintain that the Secretary denied the public a meaningful opportunity to comment on the proposed regulations. There was nothing in the proposed

[59] Providers' EJR Request at 2.
[60] *Id.* at Section I.B.4.
[61] 746 F. 3d 1102 (D.C. Cir. 2014)
[62] Provider's EJR Request at Section I.B.5.
[63] *Id.* at 1107.

regulations that suggested the possibility of anything other than the inclusion of non-covered days in the Medicare fraction or inclusion of non-covered days in the Medicaid fraction. As a result, the Providers maintain, the public was deprived of a meaningful opportunity to comment.

Accordingly, the Providers asserted that the Secretary's regulations requiring inclusion of post-2004 non-covered days in the Medicare fraction must be vacated and, as a result, the pre-FY 2005 regulations would apply.[64] The Providers' assert that "These pre-FY 2005 regulations command exclusion of all non-covered days from the *Medicare* fraction" and that "if those day must be excluded from the Medicare faction [*sic* fraction], then they must necessarily be included in the Medicaid fraction."

The EJR request also puts forward challenges to the ***substantive*** validity of the revision to § 412.106(b)(2)(i) in Sections I.B.7. Here, the Providers argue that "[t]he plain and unambiguous language of the Medicare Act mandates exclusion of non-covered days from the Medicare fraction, and inclusion of those days in the Medicaid fraction." The Providers contend that the statutory scheme establishes that Medicare secondary payor days and exhausted benefit days are not "entitled to benefits under Part A."[65]

Finally, the EJR request contends "***[a]lternatively*** . . . that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to included [*sic* include] unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare fraction."[66] In making this "alternative" contention, the EJR request notes that "[t]his contention is a separate and independent basis for granting EJR in this case" and that "the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction."[67]

The Providers point out that there are no factual matters to be resolved with respect to the issue in these cases and the Board has jurisdiction over the appeals. The Providers maintain that EJR is appropriate since the Board is without the authority to grant the relief sought, namely a finding that, as a matter of law , 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid.

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[64] Providers' EJR Request at Section I.B.6.
[65] *Id.* at 12 (citing to *Jewish Hosp. v. Secretary of Health & Human Servs.*, 19 F.3d 270 (6th Cir. 1994); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1264 (9th Cir. 1996).
[66] Providers' EJR request at 1.
[67] *Id.* (emphasis added).

Decision of the Board

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

A. Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2010-2014. For FY 2010 -2013, the two EJR requests cover both the Medicare SSI and Medicaid fractions for the Dual Eligible days issue. For 2014, the EJR request only covers the Medicare SSI fraction of the Dual Eligible days issue.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[68] 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.[69]

On August 21, 2008, new regulations governing the Board were effective.[70] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required, for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[71] 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.[72]

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[68] 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.).
[69] *Bethesda*, 108 S. Ct. at 1258-59.
[70] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[71] 201 F. Supp. 3d 131 (D.D.C. 2016).
[72] *Id.* at 142.

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

1. **Late Direct Addition to the Group Appeal under Case No. 14-4172GC**
   Participant #10 - Mercy Hospital El Reno (Prov. No. 37-0011, FYE 6/30/11)

With respect to Provider #10 Mercy Hospital El Reno (Prov. No. 37-0011, FYE 6/30/11) in Case No. 14-4172GC, the Group Representative entered the date "April 17, 2015" in Column D of the Schedule of Providers to denote the date that the hearing request was filed with/received by the Board. However, the Group Representative failed to submit any evidence/documentation to confirm the date that the Board received the Provider's request to be directly added to this group appeal, as required by the Board's Rule 21.[73] Instead, the Representative added a footnote for this Provider on the Schedule of Providers stating that the group representative "was unable to locate the delivery notification of the Model Form E." The legacy documents in the Board's Office of Hearing Case and Docket Management System ("CDMS") contain a copy of the appeal request for Mercy Hospital El Reno and revealed that the hearing request was *dated stamped* April 22, 2015 which is ***231 days*** after the issuance of the NPR (and 226 days after the Provider is deemed to have received the NPR[74]). Accordingly, the Board finds that the appeal was not timely filed within 180 days of the issuance of the final determination as required by 42 C.F.R. § 405.1835(a)(3).

The regulation, 42 C.F.R. § 405.1835(a)(3) (2015), defines the date of timely filing as "the date of receipt by the Board of the provider's hearing request [that] is no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination." The date of receipt by the Provider is presumed to be 5 days after the date of issuance of the contractor determination. The regulation 42 C.F.R. § 405.1801(1) defines the date of receipt of a hearing as evidenced by one of the following:

> (i) Of delivery where the document or material is transmitted by a nationally-recognized next-day courier (such as the United States

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[73] The Board's Rules can be found on the internet at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRules_03_01_2013.pdf. This appeal was filed when the 2013 rules here in effect.

[74] *See 42 C.F.R. §* 405.1801(a)(4)(iii) (The date of receipt by a party or affected nonparty of documents involved in proceedings before a reviewing entity is presumed to be 5 days after the date of issuance of a contractor notice or a reviewing entity document. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date.)

> Postal Service's Express Mail, Federal Express, UPS, DHL, etc.); or
>
> (ii) Stamped "Received" by the reviewing entity on the document or other submitted material (where a nationally-recognized next-day courier is not employed). This presumption, which is otherwise conclusive, may be overcome if it is established by clear and convincing evidence that the document or other material was actually received on a different date.[75]

To implement these regulations, Board Rule 21 (2013) requires that the documentation submitted with the Schedule of Providers include proof of delivery of the appeal and states:

> B. Date of Hearing Request
>
> 1. Schedule – Column B – Enter the date on which the original hearing request was filed with the Board (see Rule 4.3). If the issue under appeal was added to the individual appeal subsequent to the original appeal request, also enter the date that the request to add the issue was filed.
>
> ****
>
> • If the appeal request was filed on or after August 21, 2008, the date of filing is the date of receipt by the PRRB. See 42 C.F.R. § 405.1801(a) (2008).
>
> 2. Documentation – Tab B – A copy of the relevant pages from the initial appeal request (Model Form A or E) and the request to add, if applicable (Model Form C), including the issue statement, or other written requests filed prior to the use of such Model Forms in which this issue was appealed for the first time. In addition, *if the appeal was filed after August 21, 2008, include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue*. [March 2013][76]

Where a provider fails to include the a copy of the proof of delivery, the Board then defaults to the Board date stamp "Received" on the submission as permitted by 42 C.F.R. § 405.1801(a)(2).

In this case, the date stamp "received" for the appeal of Mercy Hospital El Reno for the fiscal year June 30, 2011 is April 22, 2015.[77] Thus, the Board's records reflect that the Provider's request to directly join Case No. 14-4172GC was received on April 22, 2015.[78] With the

[75] 42 CFR § 405.1801(a)(2) (2015).
[76] (emphasis added).
[77] *See* Enclosures for a Copy of the first page of Model Form E with the Board's date stamp.
[78] As evidenced by the date stamp on the document, see Attachment B.

allowance for the 5-day mailing period from the date the NPR was issued, the appeal was date stamped "received" in the Board's offices 226 days after the issuance of the NPR.[79] The Board's Rules regarding the submission of documentation and the proof of the date receipt of documentation have remained unchanged from the point the appeal was filed until the current time.[80] Consequently, the group representative had notice of the requirement that it is to submit proof of delivery of hearing request and, absent that documentation, the Board will refer to its date stamp "received" to determine whether the appeal was timely.[81] Here, the group representative admits it failed to maintain proper documentation of the Board's receipt of the provider's direct add request

Based on the above, the Board finds that the appeal of Participant # 10, Mercy Hospital El Reno (Prov. No. 37-0011, FYE 6/30/2011), was not filed with the Board within 180 days of the issuance of the NPR as required by 42 C.F.R. § 405.1835(a) and, hereby, dismisses the Provider from Case No. 14-4172GC. Since, pursuant to 42 C.F.R. § 405.1842(a), jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board denies the request for EJR as it relates to Participant #10, Mercy Hospital El Reno (Prov. No. 37-0011, FYE 6/30/2011). The jurisdictional determination for this Provider is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

2. **Failure to Submit Proof of Delivery for Participant in Case No. 14-1614GC**
   Participant #4 - Mercy Hospital Joplin (Prov. No. 26-0001, FYE 6/30/2010)

In Case No. 14-1614GC, the group representative included for Participant #4, (Mercy Hospital Joplin (Prov. No. 26-0001, FYE 6/30/2010), a Model Form E-Request to Join an Existing Group Appeal dated November 11, 2014 for a "Mercy Hospital for Lebanon" having Prov. No. 26-0059 behind Tab B. However, this documentation clearly did not pertain to Participant #4. The group representative dropped a footnote for this entry on the Schedule of Providers confirming that the Representative "was unable to locate the delivery notification of the Model Form E." The Representative did not furnish a copy of the Model Form E for Participant #4, Mercy Hospital Joplin (Prov. No. 26-0001, FYE 6/30/2010) as required to establish the Provider had filed a timely appeal by the Board as required by 42 C.F.R. § 405.1835(a). As a courtesy, the Board reviewed its records in Case No. 14-1614GC and could find no evidence of having received the Model Form E for this Provider.

The regulation, 42 C.F.R. § 405.1835(a)(3), an timely appeal to the Board must be filed no later than 180 days after a provider receives its final determination. Timely filing is based on the date of receipt by the Board as defined in 42 C.F.R. § 405.1801(a)(2) as evidenced by:

> (1) the date of delivery as evidenced by the courier's tracking bill for documents transmitted by a nationally-recognized next-day

[79] The actual number of days between 11/4/2014 and 6/12/15 is 220 days. Subtracting 5 days for delivery of the NPR results in a receipt date deemed to be 215 days.
[80] The Board's current Rules, effective August 29, 2018, contain the same requirements and are found in in Rules 21.3.1 and 21.3.2.
[81] In the Schedule of Providers attached to its EJR request, the Representative recognized its duty to provide the proof of delivery and admits that it "was unable to locate the delivery notification of the Model form E."

> courier. It is the responsibility of the provider to maintain record of delivery.
>
> (2) the date stamped "received" by the Board on documents submitted by regular mail, hand delivery, or couriers not recognized as a national next-day courier.

Board Rule 21 requires participants in a group appeal to submit a Schedule of Providers and supporting documentation to establish the Board's jurisdiction over the appeal. With respect to the documentation to support the timely filing of a provider's appeal, Rule 21.3.2 requires that the group representative submit a copy of the relevant pages from the initial appeal request and the request to add an issue, if applicable. In addition, if the appeal was filed after August 21, 2008, the Group Representative must include a copy of the proof of delivery (*e.g.*, USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue.

As there is no proof of the timely delivery of the direct add request, the Board hereby dismisses Participant #4 (Mercy Hospital Joplin (Prov. No. 26-0001, FYE 6/30/2010) from Case No. 14-1614GC because the Representative failed to establish that the appeal was timely filed as required by 42 C.F.R. § 405.1835(a)(2) for Board jurisdiction. Since jurisdiction over an appeal is required to grant a provider's request for EJR,[82] the Board denies the request for EJR as it relates to and denies the request for EJR as it relates to Participant #4 (Mercy Hospital Joplin (Prov. No. 26-0001, FYE 6/30/2010).

3. Failure to Submit Proof of Delivery for Participant in Case No. 17-1132GC
Participant #2 - Mercy Hospital St. Louis (Prov. No. 26-0020, FYE 6/30/14)

In Case No. 17-1132GC, the group representative included a Model Form E for Participant #2, Mercy Hospital St. Louis (Prov. No. 26-0020, FYE 6/30/2014), but did not furnish proof of the date it was received by the Board as required by Board Rule 21. As a courtesy, the Board reviewed its records in Case No. 17-1132GC and could find no evidence of having received the Model Form E for this Provider.

The regulation, 42 C.F.R. § 405.1835(a)(3), an timely appeal to the Board must be filed no later than 180 days after a provider receives its final determination. Timely filing is based on the date of receipt by the Board as defined in 42 C.F.R. § 405.1801(a)(2) as evidenced by:

> (3) the date of delivery as evidenced by the courier's tracking bill for documents transmitted by a nationally-recognized next-day courier. It is the responsibility of the provider to maintain record of delivery.
>
> (4) the date stamped "received" by the Board on documents submitted by regular mail, hand delivery, or couriers not recognized as a national next-day courier.

---
[82] *See* 42 C.F.R. § 405.1842(a).

Board Rule 21 requires participants in a group appeal to submit a Schedule of Providers and supporting documentation to establish the Board's jurisdiction over the appeal. With respect to the documentation to support the timely filing of a provider's appeal, Rule 21.3.2 requires that the group representative submit a copy of the relevant pages from the initial appeal request and the request to add an issue, if applicable. In addition, if the appeal was filed after August 21, 2008, the Group Representative must include a copy of the proof of delivery (*e.g.*, USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue.

As there is no proof of the timely delivery of the direct add request, the Board hereby dismisses Participant # 2, Mercy Hospital St. Louis (Prov. No. 26-0020, FYE 6/30/14) from Case No. 17-1132GC because the Representative failed to establish that the appeal was timely filed as required by 42 C.F.R. § 405.1835(a)(2) for Board jurisdiction. Since jurisdiction over an appeal is required to grant a provider's request for EJR,[83] the Board denies the request for EJR as it relates to Participant # 2, Mercy Hospital St. Louis (Prov. No. 26-0020, FYE 6/30/14).

4. **Improper and Void Addition to Case - Previous Dismissals**
   Case No. 14-4171GC #7 Mercy Hospital Springfield (Prov. No. 26-0065, FYE 6/30/2011)
   Case No. 14-4172GC #9 Mercy Hospital Springfield (Prov. No. 26-0065, FYE 6/30/2011)

This Provider filed an individual appeal on November 17, 2014 from a Notice of Program Reimbursement ("NPR") dated May 23, 2014, which was assigned to Case No. 15-0460. The issue appealed was "[w]hether the Secretary properly calculated the Provider's [DSH]/Supplemental Security Income ("SSI") percentage." On January 25, 2015, the group representative requested the transfer of multiple issues from Case No. 15-0460 to group appeals, among the issues to be transferred was the transfer the dual eligible days issue to Case Nos. 14-4171GC and 14-4172GC. On February 11, 2015, the group representative[84] filed copies of Model Form C (Request to Add Issue [to a case]) in Case No. 15-0460. ***On March 25, 2015***, the Board issued its jurisdictional determination in Case No. 15-0460 and found that the requests to add issues did not comply with 42 C.F.R. § 405.1835(c) which requires issues be added to appeals no later than 60 days after the expiration of the 180-day appeal period. As the issues were added to the appeal ***264 days*** *after* the issuance of the NPR, the Board found that request to add issues to Case No. 15-0460 was ***not*** timely and ***denied*** the Provider's request to transfer the issues from Case No. 15-0460 to group appeals, including the transfer of the dual eligible days issue to Case Nos. 14-4171GC (Medicaid fraction) and 14-4172GC (Medicare fraction).

Accordingly, Mercy Hospital Springfield (Prov. No. 26-0065, FYE 6/30/2011) was ***never*** *a* participant in either Case Nos. 14-4171GC and 14-4172GC and should ***never*** have been listed on the Schedule of Providers as Participant #7 and Participant #9 in these cases, respectively. Accordingly, ***the Board admonishes the group representative*** *for improperly including Mercy Hospital Springfield (Prov. No. 26-0065, FYE 6/30/2011) on the Schedule of Providers for Case Nos. 14-4171GC and 14-4172GC.* Accordingly, the Board reminds the Representative it has a responsibility to track and manage its cases and ensure it exercises due diligence prior to making

[83] *See* 42 C.F.R. § 405.1842(a).
[84] Quality Reimbursement Services.

filings. *The Board may consider taking remedial action if a trend in these types of erroneous filings continues, including for example carbon copying the underlying provider.*

5. Elimination of Duplicate CIRP Groups – EJR Requested for Both

14-1614GC Mercy Health 2010 Medicaid Fraction Dual Eligible Part A Days Group
14-1613GC Mercy Health 2010 SSI Fraction Dual Eligible Days Group

14-4171GC Mercy Health 2011 Medicaid Fraction Dual Eligible Days Group
14-4172GC Mercy Health 2011 SSI Fraction Dual Eligible Days Group

15-0388GC Mercy Health 2012 Medicaid Fraction Part A Days Group
15-0387GC Mercy Health System 2012 SSI Fraction Part A Days Group

15-3377GC Mercy Health 2013 No Part Part A Days
15-3376GC Mercy 2013 SSI Fraction Dual Eligible Days Group

The group representative established duplicate CIRP groups for the years 2010, 2011, 2012 and 2013 where the group issue statement for the CIRP groups is identical based on the Board's request for bifurcation of the original issue statement into a Medicare fraction CIRP group and a Medicaid fraction group. However, a review of the Schedules of Providers for the CIRP reveals that the group representative has ***failed*** to maintain consistent participation across the 2 CIRPs for each year and failed to treat them as distinct but related CIRP groups (as evidence by the fact that the group representative is submitted *separate but duplicate* EJR requests for each year). Rather, than sort through the implications of the group representative's failure,[85] the Board upon review of the EHR request has determined that the EJR request can be handled in one CIRP group based on the original issue statement. Accordingly, the Board is taking the following actions for each year to eliminate the duplicate CIRP group:

- For 2010, the Board is dismissing Case No. 14-1613GC as a duplicate of Case No. 14-1614GC. In this regard, the Board notes that, following the above dismissal in Case No. 14-1614GC, the participants in each group are the same.

- For 2011, the Board is dismissing Case No. 14-4171GC as a duplicate of Case No. 14-4172GC. In this regard, the Board notes that, following above dismissals in these cases, Case No. 14-4171GC is a subset of Case No. 14-4172GC where Case No. 14-4172GC has 2 additional participants.

- For 2012, the Board is dismissing Case No. 15-0388GC as a duplicate of Case No. 15-0387GC. In this regard, the Board notes that Case No. 15-0388GC is a subset of Case No. 15-0387GC where Case No. 15-0387GC has 1 additional participant.

[85] The Board notes that, as some of the CIRP groups for a year do not have the same participants as the other CIRP group for the same year, then if the Board were to find the CIRP groups were different (*i.e.*, not duplicates), then that would necessarily mean that not all participants in a year would have the same issue being appeal and could not be fully covered by the EJR request.

- For 2013, the Board is dismissing Case No. 15-3376GC as a duplicate of Case No. 15-3377GC. In this regard, the Board notes that Case No. 15-3376GC is a subset of Case No. 15-3377GC where 15-3377GC has 1 additional participant

6. **Elimination of Duplicate CIRP Groups – EJR Requested for One But Not Other**
17-1132GC QRS Mercy Health Sys. 2014 DSH Medicaid Fraction Dual Eligible Days Grp.
17-1129GC QRS Mercy Health Sys. 2014 DSH SSI Fraction Dual Eligible Days CIRP Grp.

The Mercy CIRP under Case No. 17-11**32**GC entitled "QRS Mercy Health System 2014 DSH Medicaid Fraction Dual Eligible Days Group" is included in the EJR request. This CIRP group is *fully formed* with four participants: Mercy Oklahoma, Mercy Memorial Health Center, Mercy Joplin, and Mercy St. Louis.

The Board identified another Mercy CIRP group for the same year under Case No. 17-11**29**GC entitled "QRS Merch Health System 2014 DHS SSI Fraction Dual Eligible Days CIRP Group" that has the ***exact*** *same* group issue statement as that for Case No. 17-11**32**GC. However, Case No. 17-11**29**GC only has two participants (Mercy Oklahoma and Mercy Memorial Health Center) and is ***not*** designated as fully formed. Further, the group representative has ***not*** requested EJR for Case No. 17-11**29**GC.

Similar to the cases discussed, *supra*, in Subsection A.5, these groups were formed based on bifurcation. However, the group representative has failed to maintain consistent participation across the groups and submitted an EJR request for one group that purports to represent the complete issue. Accordingly, based on the same reasoning discussed, *supra,* in Subsection A.5, the Board has determined that the EJR request can be handled in one CIRP group based on the original issue statement and is dismissing Case No. 17-1129GC which is not fully formed and whose participants are a subset of Case No. 17-1123GC. Accordingly, Case No. 17-1123GC is the surviving CIRP group which is fully formed.

7. **Dismissal of Issue That Was Added In Violation of 42 C.F.R. § 405.1837(f)(1)**

The Board notes that, on first page of their EJR request, the Providers added another issue to the group appeals which states:

> ***Alternatively***, the provider contends [*sic* providers contend] that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to include unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare Fraction. *This contention is a separate* ***<u>and</u>*** *independent basis* for granting EJR in this case. As noted below, the Board has previously recognized that it does

> not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction.[86]

The Board notes that, pursuant to the regulation, 42 C.F.R. § 405.1837(a)(2), a provider has the right to a hearing as part of a group appeal for a cost reporting period, *only if* among other things, "[t]he matter at issue in the group appeal involves a *single* question of fact or interpretation of law, regulations or CMS Rulings with is common to each provider in the group."[87] To this end, 42 C.F.R. § 405.1837(f) provides "Limitations on group appeals" and specifies in Paragraph (1) that issues may ***not*** be added to any group appeals:

> After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may* ***not*** *add other questions of fact or law to the appeal*, regardless of whether the question is common to other members of the appeal . . . ."[88]

The Board finds that the statement above is a separate and distinct issue (as recognized by the group representative through the use of the words "separate and independent" contention) and that the statement above is a new issue that was ***improperly*** added to the CIRP group appeal when the EJR request was filed. The group statement filed to establish each of these nine CIRP groups clearly does *not* challenge how ***SSI*** entitlement is determined for purposes of the DSH adjustment calculation or contend that that "eligible but unpaid SSI days be included in the numerator of the *Medicare* Fraction." Rather, the group appeal challenges how ***Medicare*** entitlement is determined and asserts that unpaid dual eligible days should be included in the *Medicaid* fraction. Since the SSI entitlement days issue is a new issue and was not part of the original group issue statement, the Board is required to dismiss the issue from the group appeal pursuant to 42 C.F.R. § 405.1837(f)(1).[89] Consequently, the Board hereby dismisses the issue from the appeal and denies the EJR request relative to improperly added SSI entitlement days issue.[90]

8. Jurisdiction for Remaining Providers and EJR

The Board has determined that the *remaining* participants involved with the instant EJR request for the above captioned CIRP groups are governed by CMS Ruling CMS-1727-R as the Providers are challenging the validity of a regulation as it relates to Dual Eligible Days. Finally, the appeals were timely filed and the remaining participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[91] Based on

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[86] (Emphasis added.)
[87] (Emphasis added.)
[88] (Emphasis added.)
[89] Moreover, the Board notes that, even if there was not the prohibition against adding issues to group appeals, the addition of this issue could not be considered timely since: (1) the add issue regulation at 42 C.F.R. § 405.1835(e) only applies to adding issues to individual appeal requests; and (2) the SSI days issue was not added to the group within the 180-day time period, as required by 42 C.F.R. § 405.1837(a)(1) (which incorporates § 405.1835(a) or § 405.1835(c)) and, thus, would not be timely.
[90] The Board further notes that the Provider failed to brief this improperly added issue as part of its EJR request.
[91] *See* 42 C.F.R. § 405.1837.

the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying, *remaining* providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

The Board finds that it lacks the authority to grant the relief sought by the Providers, namely a finding that 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid. Consequently, the Board finds that EJR is appropriate.

9. Board's Decision Regarding the EJR Request

The Board finds that:

1) That the following providers are dismissed for failure to provide proof of delivery or for not timely filing an appeal:
   a. 14-4172GC #10 Mercy Hospital El Reno (Prov. No. 37-0011, FYE 6/30/11),
   b. 14-1614GC: #4 Mercy Hospital Joplin (Prov. No. 26-0001, FYE 6/30/2010),
   c. 17-1132GC: # 2 Mercy Hospital St. Louis (Prov. No. 26-0020, FYE 6/30/14),
   d. 14-4171GC # 7 Mercy Hospital Springfield (Prov. No. 26-0065, FYE 6/30/2011), and
   e. 14-4172GC #9 Mercy Hospital Springfield (Prov. No. 26-0065, FYE 6/30/2011);

2) It must make the following action to eliminate duplicate CIRP groups for the same calendar year ("CY"):[92]
   a. Relative to CY 2010, Case No. 14-1614GC is duplicated by Case No. 14-1613GC and, therefore, the Board dismisses Case No. 14-1613GC,
   b. Relative to CY 2011, Case No. 14-4172GC is duplicated by Case No. 14-4171GC and, therefore, the Board dismisses Case No. 14-4171GC,
   c. Relative to CY 2012, Case No. 15-0387GC is duplicated by Case No. 15-0388GC and, therefore, the Board dismisses Case No. 15-0388GC,
   d. Relative to CY 2013, Case No. 15-3377GC is duplicated by Case No. 15-3376GC and, therefore, the Board dismisses Case No. 15-3376GC, and
   e. Relative to CY 2014, Case No. 17-1132GC is duplicated by Case No. 17-1129GC (for which the Provider did not request EJR and has not certified as complete) and, therefore, the Board dismisses Case No. 17-1129GC;

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

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

[92] Note that the Schedules of Providers included at Attachment A only reflect the surviving CIRP groups, i.e., Case Nos. Case No. 14-1614GC, Case No. 14-4172GC, Case No. 15-0387GC, Case No. 15-3377GC, and Case No. 17-1132GC.

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

6) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i) codifying the Medicare dual eligible days policy adopted in the FY 2005 IPPS final rule is valid and to provide the requested relief that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."[93]

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (2005) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years as stated above. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

<u>Board Members Participating:</u>

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

FOR THE BOARD:

9/30/2021

Clayton J. Nix, Esq.
Chair
Signed by: PIV

Enclosures: Attachment A - Schedules of Providers
Attachment B - First page of Model Form E for Mercy Hospital El Reno

cc: Byron Lamprecht, WPS
Wilson Leong, FSS

[93] *Id.* at 1.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Jurisdictional Determination in for Stanford Health Care***
Valleycare (Prov. No. 05-0283)
FYE 6/30/2016
Case No. 21-1561

Dear Ms. Ellis and Ms. Frewert:

The Provider Reimbursement Review Board ("Board") has reviewed the subject individual appeal filed by Toyon Associates, Inc. ("Toyon" or "Representative") subsequent to a review of the ***same*** *Provider's* participation in two optional group appeals from the ***same*** determination. The pertinent facts with regard to the Provider's appeal and the jurisdictional determination of the Board, are set forth below.

Pertinent Facts

On August 13, 2021, Toyon filed a request to establish an individual provider appeal under Case No. 21-1561 for Stanford Health Care - Valleycare (Prov. No. 05-0283) ("Valleycare" or "Provider") for the fiscal year ending ("FY") 6/30/2016. The individual appeal includes two issues:

1. DSH Accuracy of CMS Developed SSI Ratio; and
2. DSH Inclusion of Medicare Part C Days in the SSI Ratio.

The appeal was filed from a Notice of Corrected Reimbursement issued as a result of the Provider's request for realignment.[1]

Based on a review of the supporting documentation, it is noted that:

- On July 27, 2020, Toyon requested a Reopening for Valleycare "request[ing] a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year." This reopening request was made "pursuant to 42 CFR

[1] Valleycare's final determination from which it is appealing is titled "Notice of Corrected Reimbursement," referred to hereinafter as "RNPR."

412.106(b)(3)" which is the regulation governing requests to realign the SSI ratio (as used in the DSH adjustment calculation) from the federal fiscal year to a provider's fiscal year.

- On August 7, 2020, the MAC issued the Notice of Reopening "To adjust the SSI ratio used to calculate the Provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period *rather than the federal fiscal year*. [2]

- On February 15, 2021, the Medicare Contractor issued the RNPR.

- the adjustments being appealed from the RNPR is Audit Adjustment No. 4. Adjustment 4 adjusted the SSI Percentage from 5.92 to 6.27 based on the realignment. The other adjustments affected the recalculation of the DSH percentage.

Valleycare's Direct Add Requests to optional groups:

Prior to filing the individual appeal for Valleycare, on August 4, 2021, Toyon requested that the Board reopen the status of two optional groups to allow the addition of Valleycare's appeal from its RNPR:

- Case No. 19-2381G for "Toyon Associates CY 2016 Accuracy of CMS Developed SSI Ratio Group"; and
- Case No. 19-2380G for "Toyon Associates CY 2016 DSH Medicare Part C - SSI Ratio/DE Part C - Medicaid Ratio Group."

On August 30, 2021, the Board issued a determination in which it declined Toyon's request to reopen the status of the fully formed groups to allow the direct addition of Valleycare (Prov. No. 05-0283). The Board found that it did ***not*** have jurisdiction over the SSI Accuracy and Medicare Part C days issues appealed from the RNPR because the RNPR was issued as a result of the Provider's realignment request and did not adjust either group issue.

Board's 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 $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The 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:

[2] (Emphasis added.)

> (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.

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider ... has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the

> provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[3]

Accordingly, pursuant to 42 C.F.R. § 405.1889(b) (and § 405.1835(a)(1) which references that regulation), the Board has jurisdiction only over those matters that have been "specifically revised" in a revised determination. More specifically, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4]

Here, the Board finds that it does not have jurisdiction over the SSI Accuracy and Medicare Part C Days issues for Valleycare (05-0283) appealed from the RNPR because the RNPR was issued as a result of the Provider's SSI Realignment request, and did not adjust either of the two issues under appeal in this individual appeal. As a result, the Provider does not have the right to appeal this determination under 42 C.F.R. § 405.1889(b) as referenced in §405.1835(a)(1).

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

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

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[3] (Emphasis added.)
[4] 42 C.F.R. § 405.1889(b)(1).
[5] (Emphasis Added.)

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

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

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether ornot it is a more favorable number than the DSH percentage based on the Federal fiscal year. . . .*

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

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

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

Since the only matter specifically revised in the RNPR was an adjustment related to realigning the SSI percentage from the Federal fiscal year to the hospital's fiscal year, the Provider (Valleycare) does not have a right to appeal the SSI Accuracy or Medicare Part C Days issues under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1). The Board hereby closes Case No. 21-1561 and removes it from the docket. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[9]

Indeed, the Provider has already ***previously appealed*** these **<u>same</u>** two issues *from its original NPR* where: (a) it was transferred to Case No. 19-2381G for the SSI Accuracy Issue; and (b) it was transferred Case No. 19-2380G for the Medicare Part C days. The Provider is still an active participant in Case No. 19-2380G based on the *original NPR* appeal.[10] Thus, the appeal of Case No. 21-1561 otherwise duplicates appeals that are already pending before the Board in another case. ***The Board reminds Toyon*** that, pursuant to Board Rule 4.6.2, "Appeals from the ***same*** issue from distinct determinations [for the same year] must be pursued in a ***single*** appeal."[11] In other words, Board Rules prohibit Toyon from pursuing duplicate appeals of the *same* issue for the *same* year and provider in multiple appeals.

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.

<u>Board Members Participating</u>:
Clayton J. Nix., Esq.
Gregory H. Ziegler, CPA
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Susan A. Turner, Esq.
Kevin D. Smith, CPA

For the Board:

9/30/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

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

[9] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[10] ValleyCare (*transfer based on original NPR*) was withdrawn from Case No. 19-2381G on October 30, 2020.
[11] (Emphasis is added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination***
Hall Render CY 2016 DSH SSI Ratio Dual Eligible Days Group
Case No. 18-1810G

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 20, 2020 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal, in addition to the MAC's substantive cost report claim challenge filed February 23, 2021[1] and the Provider's March 1, 2021 response. The Board's decision with respect EJR is set forth below.

Effect of COVID -19 on Board Operations and Staying of 30-day Period For Responding to EJR Requests:

By letter dated April 15, 2020, the Board sent the Group Representative notice for this CIRP group that the 30-day time period for issuing an EJR had been stayed consistent with Board Alert 19. As explained below, that stay remains in effect. On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services ("CMS") required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties "Temporary COVID-19 Adjustments to PRRB Processes." On April 15, 2020, subsequent to the submission of the EJR request, the Board notified you of the Issue in relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42

[11] The Board issued a scheduling order on February 8, 2021, for the parties, as necessary, to brief any substantive cost report claim arguments within 21 days, to ensure the record was complete ad a ruling could be make under 413.24(j).

C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned CIRP appeal.

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on October 7, 2019, the Board did not receive the EJR request for the above-referenced appeal in its office until March 20, 2020, after the Board and its staff had begun to telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

Issue in Dispute:

The issue for which the Board is considering EJR is:

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

Medicare Disproportionate Share Hospital (DSH) Payment Background:

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

[2] Providers' EJR Request at 2.
[3] 42 C.F.R. Part 412.
[4] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[5] (Emphasis added.)

entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

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

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[7] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[8] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[9]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar

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[6] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[7] 42 U.S.C. § 1382.
[8] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[9] 20 C.F.R. § 416.202.

months.[10] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[11]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[12] and may terminate,[13] suspend[14] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[15] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[16]
2. The individual fails to apply for other benefits to which the individual may be entitled;[17]
3. The individual fails to participate in drug or alcohol addiction treatment;[18]
4. The individuals is absent from the United States for more than 30 days;[19] or
5. The individual becomes a resident of a public institutions or prison.[20]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[21]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[22] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records

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[10] 42 U.S.C. § 426.
[11] 42 U.S.C. § 426-1.
[12] 20 C.F.R. § 416.204.
[13] 20 C.F.R. §§ 416.1331-1335.
[14] 20 C.F.R. §§ 416.1320-1330.
[15] 20 C.F.R. § 1320.
[16] 20 C.F.R. § 416.207.
[17] 20 C.F.R. § 416.210.
[18] 20 C.F.R. § 416.214.
[19] 20 C.F.R. § 416.215.
[20] 20 C.F.R. § 416.211.
[21] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[22] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).

from the SSI file compiled by SSA.[23] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[24] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[25] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[26]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[27]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II

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[23] *Id.*
[24] *Id.*
[25] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[26] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[27] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

numbers."[28] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[29] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[30]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[31] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[32]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[33] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[34] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[35] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[36] Finally, in the preamble, CMS confirms that "[t]he same data matching process

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[28] CMS-1498-R at 5.
[29] *Id.*
[30] *Id.* at 5-6.
[31] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[32] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[33] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[34] *Id.* at 50280.
[35] *Id.* at 50280-50281.
[36] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.

[used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[37]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[38] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[39] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[40]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[41]

As a result of the Rulings, new regulation, and new data match process, CMS calculated SSI percentages for the Providers for all of fiscal years at issue in this CIRP group appeal.[42] The Providers have appealed original NPRs a based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

Providers' Request for EJR:

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

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[37] *Id.* at 50285.
[38] CMS-1498-R at 6-7, 31.
[39] *Id.* at 28, 31.
[40] 75 Fed. Reg. at 24006.
[41] CMS-1498-R2 at 2, 6.
[42] CMS published the SSI ratios for FY 2015 on or about July 6, 2017. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

Social Security Administration ("SSA") for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[43]

The Providers note that, in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[44] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the DSH statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' disproportionate patient percentage ("DPP") calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA").[45]

Decision of the Board:

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

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to

[43] 75 Fed. Reg. at 50275-86.
[44] *Id.* at 50281.
[45] Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).

their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [46]

- The matter at issue involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[47]

A. Jurisdiction

1. Jurisdiction of participants appealing NPRs Beginning Prior to January 1, 2016

a. CMS Ruling 1727-R

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[48] 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.[49]

On August 21, 2008, new regulations governing the Board were effective.[50] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[51] 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.[52]

[46] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[47] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[48] 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.).
[49] *Bethesda*, 108 S. Ct. at 1258-59.
[50] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[51] 201 F. Supp. 3d 131 (D.D.C. 2016).
[52] *Id.* at 142.

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

b. Analysis under 1727-R regarding the appealed issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a *revised* data match.[53] The Secretary also stated in the Ruling that, where cost reports had not been settled, those providers SSI fraction would be calculated using the *revised* data match process to be published through rulemaking.[54]

Contemporaneous with CMS Ruling 1498-R[55] the Secretary published a proposed IPPS rule[56] which proposed to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the 2011 Final IPPS Rule in which the Secretary explained that:

> . . . we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[57]

[53] CMS Ruling 1498-R at 27.
[54] *Id.* at 31.
[55] *Id.* at 5.
[56] 75 Fed. Reg. 23852, 24002-07.
[57] 75 Fed. Reg. at 50277.

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[58]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[59]

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

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[60] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility. As a result, the Board has determined that the participants involved with the instant EJR request with cost reporting periods beginning *prior to* January 1, 2016 are governed by CMS Ruling CMS-1727-R.

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[58] (Medicare) Enrollment Database.
[59] 75 Fed. Reg. at 50285.
[60] 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 . . . ."

c. <u>Jurisdictional Determination for those participants appealing NPRs Beginning **Prior to** January 1, 2016</u>

There are seven total participants as noted on the attached Schedule of Providers. The participants' appeals with cost reporting periods beginning *prior to* January 1, 2016 filed a timely and proper appeals to be directly added to the optional group and either protested the SSI Dual Eligible Days issue or met the dissatisfaction requirement based on CMS Ruling 1727-R as discussed, *supra*. Accordingly, the Board finds that it has jurisdiction over these participants. Accordingly, the Board finds that it has jurisdiction over these participants.

2. Jurisdiction of the participants appealing NPRs <u>beginning on</u> January 1, 2016

The three (3) remaining Providers are appealing from cost reporting periods beginning ***on*** January 1, 2016 based on an NPR. The Board notes that the November 13, 2015 OPPS Final Rule *eliminated* the ***jurisdictional*** requirement of an appropriate cost report claim in existing §§ 405.1835(a)(1) and 405.1840(b)(3) for Board appeals of cost reporting periods beginning on or after January 1, 2016.[61] Based on its review of the record, the Board finds that each of these Providers filed timely and proper appeals to be directly added to the group. Accordingly, the Board finds that it has jurisdiction over these participants.

3. Jurisdiction over the group appeal

The Board has substantive jurisdiction of the group issue and documentation of the participants shows that that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[62]

Based on the above, the Board finds that it has jurisdiction for the above-captioned CIRP 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.

[61] 80 Fed. Reg. 70298 (Nov. 13, 2015).
[62] *See* 42 C.F.R. § 405.1837.

B. Appropriate Cost Report Claim Analysis Under 42 C.F.R. §§ 413.24(j) and 405.1873 for Those Participants Appealing NPRs Beginning on January 1, 2021

On February 8, 2021, the Board requested additional information from the Group Representative regarding three (3) of the seven (7) total participants in the appeal that had NPRs beginning on January 1, 2021 and, thereby, were subject to 42 C.F.R 413.24(j). Specifically, the Board asked for both parties to review and supplement the record if necessary with additional evidence or argument for the following three participants:

- Participant No. 1: Conway Regional Medical Center (Prov. No. 04-0029) ("Conway");
- Participant No. 4: Norton Hospitals, Inc. (Prov. No. 18-0088); and
- Participant No. 5: Memorial Healthcare (Prov. No. 23-0121) ("Memorial").

Both the Medicare Contractor and the Group Representative responded to that request on February 23, 2021 and March 1, 2021, respectively. The Medicare Contractor raised a cost report claim dispute for only two of the above three participants, namely Participant No. 1, Conway, and Participant No. 5, Memorial. Neither party requested that the Board conduct any oral proceedings on the Substantive Claim Challenge.[63]

1. Regulatory Background

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the <u>specific</u> item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for

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

> example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **<u>and</u> describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[64]

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

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

[64] (Bold and underline emphasis added.)

> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[65]

These regulations are applicable to the cost reporting period of three (3) group participants in this case. Position papers have not been filed, but following the Board's February 8, 2021 Request for Information, the parties submitted briefs with regard to whether the two Providers included an appropriate cost report claim for the disputed issue.

2. Medicare Contractor's Argument

For Conway, the Medicare Contractor notes that the cited adjustment is for the Provider's SSI percentage and DSH percentage based on incorporation of the updated SSI ratio and "does not indicate that the Provider sought to claim full reimbursement for the specific item in dispute [i.e., SSI Ratio Dual Eligible Days] in accordance with Medicare policy."[66] Additionally, it argues

[65] (Bold and underline emphasis added.)
[66] Medicare Administrative Contractor Substantive Claim Letter at 5 (Feb. 23, 2021).

that the Provider's cost report identified $0 in Part A Protested Amounts, which was not adjusted, and as such "the Provider did not establish a self-disallowed item for additional dual eligible days within the SSI fraction."[67] Finally, the Medicare Contractor states none of the exceptions in subsections 3(i) through 3(iii) of the regulation apply.[68]

For Memorial, first the Medicare Contractor notes that the specific number of SSI fraction dual eligible days claimed by the Provider on its cost report was not adjusted.[69] While the cost report was adjusted to remove $69,777 in Part A Protested Amounts,[70] the Medicare Contractor states that the accompanying schedule of protested items does not include anything for dual eligible days in the SSI fraction.[71] Finally, the Medicare Contractor states none of the exceptions in subsections 3(i) through 3(iii) of the regulation apply.[72]

3. Group Representative's Response

On March 1, 2021, the Group Representative filed its response to the Medicare Contractor's Substantive Claim Challenge. At the outset, the Group Representative disagreed with the Medicare Contractor's Substantive Claim Challenge to Conway and Memorial and asserts that "each Provider ***has fulfilled*** the requirements laid forth in 42 C.F.R. §§ 413.24(j) and 405.1873."[73] Specifically, the Group Representative argues:

> The cost report items in dispute are the Providers' SSI, DSH, and DPP adjustments. To submit an appropriate claim, the Providers "must include an appropriate claim for the specific item, by ***either***— (i) Claiming full reimbursement in the provider's cost report *for the specific item* in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; ***or*** (ii) Self-disallowing *the specific item* in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item)." § 413.24(j) (emphasis added).
>
> ***
>
> Here, the Providers' SSI, DHS, and/or DPP adjustments are the specific items for which they seek supplemental reimbursement on

[67] *Id.* and Exhibit C-2 at 5.
[68] Medicare Administrative Contractor Substantive Claim Letter at 5.
[69] *Id.*
[70] Exhibit C-2 at 19.
[71] The protested items are (1) Medicare part C days in the SSI fraction; (2) Dual eligible days in the Medicaid fraction; (3) Part C days in the Medicaid fraction; (4) General SSI; and (5) Medicaid eligible days.
[72] Medicare Administrative Contractor Substantive Claim Letter at 5-6.
[73] (Emphasis added.)

> appeal. The Providers claimed full reimbursement for the specific items, and the MAC awarded reimbursement for them in accordance with Medicare policy.
>
> The regulation does not require that the Providers *also* expressly self-disallow *supplemental* payment sought for the same items under a purely legal challenge beyond the MAC's authority to address. It only requires that an appropriate claim for the specific item be included by *either* claiming full reimbursement in accordance with Medicare policy ***or*** self-disallowing the item. Where some reimbursement for the item is available, it is nonsensical to require that the Provider instead self-disallow the item, foregoing available reimbursement in favor of seeking greater reimbursement in a future appeal. And the Supreme Court has already said that "the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations." *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 404 (1988). Further, because the MAC and CMS refuse to produce any meaningful information about the content of the SSI Ratio, it is impossible to correctly file a protested amount because we do not have access to the data necessary to calculate a fiscal impact.

The Group Representative further argues that, since the Secretary is in control of the underlying data related to DSH payment calculations, the burden of production shifts away from the hospital with regard to the argument that Provider's SSI adjustments are not due any additional Dual Eligible days.[74] Essentially, the Group Representative claims the Provider filed its cost report using the SSI ratio provided by CMS thus made a full claim for reimbursement of that specific item, and that since an adjustment was made to its SSI percentage it was unnecessary and futile to *also* self-disallow the same specific item.[75]

Specifically, with regard to Conway, the Group Representative argues:

> Conway was not required to also self-disallow the same items it included in its claim for reimbursement when it cited adjustment #36. (Exhibit P-1 is Conway's Tab D for this appeal.) This adjustment deals directly with the SSI and DSH percentage, so there was no reason to provide any additional citation. In the appeal at issue, it would be futile to require Conway to have self-disallowed a specific item. As laid by the court in *Pomona*, the Secretary holds the keys to the DSH calculation, and if the Secretary has issues with what the Providers appeal, then the burden shifts to the Secretary to prove the Providers' SSI Ratios do not provide the correct basis for an appeal.

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[74] *Id.* at 3-5 (citing *Pomona Valley Hosp. Med. Ctr. v. Azar*, 2020 WL 5816486 (D.D.C. 2020)).
[75] *Id.* at 5.

Specifically, with regard to Memorial, the Group Representative makes the same arguments it made for Conway and, in addition, argues that Memorial's protesting the number of dually eligible days in the *Medicaid* Fraction is sufficient to meet the 42 C.F.R. § 413.24(j) requirements: "Memorial protested its dually eligible days, and that should be the end of the analysis."[76]

The Group Representative concludes its response with a lengthy discussion and argument regarding why the substantive claim requirements found in 42 C.F.R. §§ 413.24(j) and 405.1873 are substantively invalid and should be disregarded by the Board.[77] Specifically, the Group Representative then argues, in the alternative, that "42 C.F.R. §§ 413.24(j) and 405.1873 violate the Providers' statutory right to a meaningful appeal under 42 U.S.C. § 1395oo(a), as already determined by *Bethesda*, *Banner*, and *Bayshore*." Accordingly, the Group Representative has presented a challenge to the ***substantive*** validity of 42 C.F.R. §§ 413.24(j) and 405.1873 based on the arguments that:

- "The statutory and regulatory cost reporting framework demonstrates that the 2016 Regulation imposes improper requirements for submitting a cost report for the apparent purpose of undermining providers' appellate rights."
- "The Supreme Court in Bethesda rejected CMS's pre-2008 policy that the "dissatisfied" jurisdictional element required administrative exhaustion even when administrators lacked authority to adjudge the dispute."
- "Applying Bethesda, the D.C. District Court in Banner invalidated CMS's 2008 regulation requiring administrative exhaustion to satisfy the "dissatisfied" jurisdictional requirement."
- "The Board should disregard CMS's 2016 Regulation requiring administrative exhaustion as a prerequisite to payment under the same reasoning in Bethesda and Banner."

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

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[78] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included ***when a party questions*** whether, pursuant to 42 C.F.R. § 405.1873(a), a provider "included an appropriate claim for the specific item" under appeal in the cost report at issue.

[76] *Id.*
[77] *Id.* at 5-18.
[78] (Emphasis added.)

The Board notes that there are three participants in this group that have cost reports beginning on January 1, 2016 and are, thereby, subject to the "Substantive reimbursement requirement of an appropriate cost report claim" delineated in 42 C.F.R. § 413.24(j)—Conway, Norton Hospitals and Memorial. However, a question regarding these participants compliance with the requirement has only been raised with respect to 2 of these participants – Conway and Memorial.

At the outset, the Board notes that, since neither party raised such a question with respect to Participant No. 4, Norton Hospitals, no Board inquiry is triggered under 42 C.F.R. § 405.1873(b). Accordingly, the Board is ***not*** required to review (nor include any findings) on that question and so the Board includes no such findings herein regarding Norton Hospitals.

With regard to Conway and Memorial, the Board recognizes that the Group Representative has raised arguments challenging the *substantive* validity of 42 C.F.R. §§ 413.24(j) and 405.1873 and that, as the Board is otherwise bound by these regulations, it does not have the authority to decide those legal questions. However, those arguments are made ***in the alternative***. For both Conway and Memorial, the Group Representative *first* argues that, contrary to the Medicare Contractor's assertion, they actually met the requirements of these regulations. Accordingly, EJR of these in-the-alternative arguments is *not* appropriate because the Board must resolve and issue a decision on the factual dispute between the parties on whether those requirements were met. The Board notes that review of the Board's factual and legal findings regarding that dispute may be available pursuant to 42 C.F.R. §§ 405.1842(g) and 405.1875(a)(2)(v) and that such review necessarily would encompass the Group Representative's in-the-alternative arguments regarding the substantive validity of 42 C.F.R. §§ 413.24(j) and 405.1873.[79] Accordingly, the Board has set forth below its factual and legal findings on that question regarding these two participants, Conway and Memorial.

a. <u>Conway</u>

The Board finds that Conway ***failed*** to comply with 42 C.F.R. § 405.1824(j) and include "an appropriate claim for the ***specific*** item"[80] under appeal in this group for the SSI Dual Eligible Days issue. The Group Representative recognizes that there are two methods by which a provider can comply with the § 405.1824(j) requirement to "include an appropriate claim for the <u>specific</u> item" on the cost report by either claiming reimbursement for that specific item as delineated at § 405.1824(j)(1)(i) or self-disallowing the specific item as delineated at § 405.1824(j)(1)(ii). The Group Representative concedes Memorial did not self-disallow the SSI Dual Eligible Days issues by protesting it but asserts that Memorial met the first method of claiming reimbursement for the specific item under § 405.1824(j)(1)(i).

The Board finds that Conway failed to either claim or self-disallow the SSI Dual Eligible Days issue and does not meet any of the exceptions in § 413.24(j)(3)(i) through 3(iii) as the exceptions only apply only to situations where there is an amended cost report, a reopening or an adjustment of

[79] Note that Administrator review under 42 C.F.R. § 405.1875(a)(2)(v) is referenced in § 405.1842(g). *See also* 42 C.F.R. § 405.1873(f)(2).
[80] 42 C.F.R. § 405.1873(a).

the specific item by the Medicare Contractor. The Board notes that the record is clear (and the Group Representative concedes) that Conway did ***not*** self-disallow the SSI Dual Eligible Days issues by protesting it on the cost report at issue. With regard to claiming the specific item on the cost report, the Board notes that § 405.1824(j)(1)(i) describes this method of compliance as follows:

> Claiming ***full*** *reimbursement* in the provider's cost report *for the specific item* in accordance with Medicare policy, ***if*** the provider seeks payment for the item that it believes comports with program policy; . . . .

The Board finds that Conway failed to satisfy this requirement because it failed to claim "***full*** reimbursement"[81] for the specific item under appeal, namely the SSI Dual Eligible Days issue. The Board finds the Group Representative is misplaced in arguing that it "claimed full reimbursement for the specific item[]" and that "the MAC awarded reimbursement for them in accordance with Medicare policy." Conway could not claim "full reimbursement" on its cost report for the Dual Eligible Days issue that is the subject of this EJR because it did not "comport with [Medicare] program policy (meaning that CMS' policy is only to count SSI paid days as opposed to SSI eligible days as advocated by Conway). This finding is supported by the fact that there is no adjustment on the NPR at issue for the Dual Eligible Days issue (and hence the exception under § 413.24(j)(3)(ii) does not apply). The only cited adjustment to the cost report was for the Provider's SSI percentage and DSH percentage based on incorporation of the updated SSI ratio issued by CMS (in accordance with its policy) and, thereby, did not include the SSI Ratio Dual Eligible Days issue which disputes CMS' policy.

Based on these findings, the Board finds that Conway failed to specifically include a substantive claim for the group's SSI Dual Eligible Days issue as required under 42 C.F.R. § 413.424(j)(1).

b. Memorial

For Memorial, the Group Representative argue that it met both methods in subparagrpahs (i) or (ii) of 42 C.F.R. § 413.424(j)(1) for including "an appropriate claim for the ***specific*** item"[82] under appeal in this group for the SSI Dual Eligible Days issue. The Board disagrees.

The Board similarly uses the same reasoning process as it did for Conway (*see supra*) to find that Memorial *failed* to include an appropriate cost report claim for SSI Dual Eligible Days issue under the method delineated at § 413.424(j)(1)(i) because it failed to claim "***full*** reimbursement"[83] for the specific item under appeal, namely the SSI Dual Eligible Days issue and failed to qualify for any of the exceptions in § 413.24(j)(3)(i) through 3(iii).

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[81] (Emphasis added.)
[82] 42 C.F.R. § 405.1873(a).
[83] (Emphasis added.)

The Board also finds that Memorial failed to self-disallow the SSI Dual Eligible Days issue ***that is the subject of this EJR request***. The record reflects that Memorial only protested 5 DSH items:

(1) "CMS improperly includes Medicare Advantage Days in the SSI Fraction . . . .";

(2) "The Provider is protesting the Omission from the Provider's 'Medicaid Fraction' Days attributable to Patients Who Were Dually Eligible for Medicare Part A and Medicaid, But Whose Medicare Part A Benefits Were Exhausted When Calculating the Provider's DSH Payment for Operating and Capital . . . .";

(3) "CMS improperly include Medicare Advantage Days in the Provider's 'Medicare Fraction' . . . .";

(4) "CMS Erred When It Incorrectly Calculated the Provider's SSI 'Medicare Fraction' for Purposes of Calculating the Provider's DSH Adjustment for Operating and Capital . . . .";

(5) "[T]he hospital is protesting the number of Medicaid eligible days [included in the Medicaid fraction] based on the limitation of information from the state at the time of filing."

Of the above 5 DSH-related protested items, only Nos. 2 and 4 are remotely related to the issue ***that is the subject of this EJR***. The DSH protested Item No. 2 only pertains to the Medicaid fraction asserting that the *Medicaid* fraction is undercounted because it does not include dual eligible whose Medicare Part A benefits were exhausted. In contrast, the issue that is the subject of the EJR only pertains to the *SSI* fraction (aka the Medicare fraction) and does ***not*** involve the Medicaid fraction. Specifically, the EJR request is alleging that the *SSI* fraction is undercounted because CMS incorrectly counting only SSI paid days rather than more broadly SSI eligible days. Accordingly, the Board finds that the DSH Protested Item No. 2 does not pertain to the issue *that is the subject of this EJR*.

While the Group Representative does not discuss the DSH Protested Item No. 4, the Board nevertheless reviewed it and concluded it was not applicable. The Board notes that the issue described in that item is too broad and nebulous in that it simply states "CMS Erred When It Incorrectly Calculated the . . . Medicare Fraction." As noted above, 42 C.F.R. § 405.1824(j)(2) provides the following instruction on self-disallowing:

> (1) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and

> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

The Board finds that the DSH Protested Item No. 4 fails to define the "specific item"[84] it is protesting and is too generic to have any meaning. This Provider has not complied with the mandates of § 413.24(j)(2) to sufficiently describe the "specific item" being self-disallowed.[85] Finally, in its response to the Substantive claim challenge, the Group Representative does not point to this protest item but rather only points to the no-pay Dual Eligible days protested item, which as previously noted is clearly not applicable.

Based on these findings, the Board finds that Memorial failed to specifically include a substantive cost report claim for the group's SSI Dual Eligible Days issue as required under 42 C.F.R. § 413.424(j)(1).

C. Board Analysis of the EJR Request

The Board's analysis of the EJR request is included in Subsection A.1.b entitled "Analysis under 1727-R regarding the appealed issue." This analysis demonstrates that, in the preamble to the FY 2011 Final IPPS Rule, the Secretary adopted the Uncodified SSI Data Match Regulation and that the Board is otherwise bound to apply that regulation. As a result, the Board does not have the authority to decide on the Providers' challenge of the validity of that regulation.

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 all of the participants in this CIRP group appeal are entitled to a hearing before the Board;

2) A questioned was raised under 42 C.F.R. § 405.1873(a) whether the following two participants (which appealed cost reporting periods beginning on January 1, 2016) failed to include "an appropriate claim for the specific item" that is the subject of the group appeal as required under 42 C.F.R. § 413.24(j)(1) and following an inquiry conducted pursuant to 42 C.F.R. § 405.1873(b) found that these two participants did, in fact, fail to

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[84] The Board notes that both 42 C.F.R. § 413.424(j) and 42 C.F.R. § 405.1835 use the term "specific item." Accordingly, the Board also looks to how it has applied and interpreted that term as it is used in 42 C.F.R. § 405.1835 as guidance in applying § 413.424(j). *See also* Board Rule 8.

[85] *See supra* note 84. Further, the Board notes that the Provider filed to describe how the provider calculated the estimated reimbursement of $2454 for this protested item, more specifically how it determined that there an "error in the Medicare SSI Percentage" of 0.13 percent that equates to the $2454.

include "an appropriate claim for the specific item" on their cost report at issue for the "specific item" that is the subject of the group appeal as required under C.F.R. § 413.24(j)(1) and that none of the exception under § 413.24(j)(3) applied:

a. Participant No. 1: Conway Regional Medical Center (Prov. No. 04-0029)
b. Participant No. 5: Memorial Healthcare (Prov. No. 23-0121)

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

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

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

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation (as adopted in the preamble to the 2011 Final IPPS 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 years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

<u>Board Members Participating:</u>

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

FOR THE BOARD:

9/30/2021

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

Enclosures: Schedule of Providers

cc: Byron Lamprecht, WPS Government Health Administrators
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
13-1507GC – North Shore LIJ 2008 Inclusion of DSH Advantage Days in the SSI Fraction Grp
13-1510GC – North Shore LIJ 2008 Exclusion of Medicaid Eligible DSH Advantage Days from the Medicaid Fraction Group
15-3246GC – North Shore LIJ 2011 Post-Allina Decision Medicare Part C Days Group

Dear Ms. Webster:

The above-referenced three (3) common issue related party ("CIRP") group appeals[1] include a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

The subject CIRP groups are full formed.[2] On September 23, 2021, the Providers in the above-referenced CIRP group appeals filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue, asking the Board to grant EJR despite the issuance of CMS Ruling 1739-R, and further challenging said ruling.[3] The Board's decision to bifurcate the Provider's EJR request, and grant it in part and deny it in part, is set forth below.

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

[2] The Board notes that, with respect to fully formed or complete CIRP groups, 42 C.F.R. 405.1837(e)(1) states, in pertinent part: "When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, ***no other provider under common ownership or control may appeal to the Board the issue*** that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal." (Emphasis is added.)

[3] Providers' Petition for Expedited Judicial Review (Sep. 23, 2021), PRRB Case no. 13-1507GC; *Id*. at PRRB Case Nos. 13-1510GC, 15-3246GC.

Statutory and Regulatory Background

Medicare Advantage Program

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

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

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

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[6]

With the creation of Medicare Part C in 1997,[7] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under

[4] of Health and Human Services.
[5] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[6] *Id.*
[7] 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-

Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[8]

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 . . . .*[9]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[10] 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.[11]

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

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173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

[8] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[9] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[10] 69 Fed. Reg. at 49099.

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

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.[12] 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).[13] 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."[14]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[15] 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.[16] In *Allina Health Services v. Price* ("*Allina II*"),[17] 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*.[18] 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.[19] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[20]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient

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[12] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[13] *Id*. at 47411.
[14] 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).
[15] 746 F. 3d 1102 (D.C. Cir. 2014).
[16] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[17] 863 F.3d 937 (D.C. Cir. 2017).
[18] *Id*. at 943.
[19] Id. at 943-945.
[20] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).

percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[21] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[22] The Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[23]

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

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

[21] CMS Ruling 1739-R (Aug. 17, 2020).
[22] *Id*.
[23] *Id*.

> further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[24]

Providers' Request for EJR

The Providers within the CIRP group appeals are challenging their Medicare reimbursement for the fiscal year 2008 and 2011 cost reporting periods. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[25] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[26] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[27] As such, the Providers conclude that the Board is "required" to grant EJR.[28]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[29] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[30]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here….[31]

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[24] CMS Ruling 1739-R at 6-7.
[25] Providers' Petition for Expedited Judicial Review (Sep. 23, 2021), PRRB Case no. 13-1507GC; *Id*. at PRRB Case Nos. 13-1510GC, 15-3246GC.
[26] *Id*. at 1.
[27] *Id*.
[28] *Id*. at 1-2.
[29] *Id*. at 11-12.
[30] *Id*. at 21.
[31] *Id*. at 13-14.

> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz,* 536 U.S. 622, 627 (2002)).[32]
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> . . . .
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> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[33]

Board's Analysis and Decision

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

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

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

[32] *Id*. at 14.
[33] *Id*. at 17.

Board's Authority

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

The Board's analysis is detailed below.

Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[34, 35]

The Providers included in the instant EJR requests filed appeals from original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods for 12/31 2008 through 12/31 2011, or from the MAC's failure to issue a timely final determination.

With respect to the "dissatisfaction" prong of the Board's jurisdiction regulation, for cost report periods ending prior to December 31, 2008, a provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[36] 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.[37]

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[34] 42 C.F.R. § 405.1835(a).
[35] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[36] 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.).
[37] *Bethesda* at 1258-59.

On August 21, 2008, new regulations governing the Board were effective.[38] 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*").[39] 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.[40]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R ("CMS 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods that ended on or after December 31, 2008, and began before January 1, 2016, that were pending or filed on or after April 23, 2018.[41] Under this Ruling, if the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) is no longer applicable. However, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.[42]

For participants who did not have NPRs, a provider may request a hearing from the Board if the MAC fails to issue a final determination for its perfected cost report within 12 months of the date of receipt of the cost report (or accepted amended cost report) by the MAC.[43] The statute does not require dissatisfaction for an appeal based on the untimely issuance of an NPR.[44] Further, the provider has 180 days from the expiration of the 12-month period to file its appeal.[45]

The Providers included in the instant EJR request filed appeals of original NPRs or failure to issue timely determinations[46], between 12/31/2008 and 12/31/2011 and are governed by CMS Ruling CMS-1727-R.[47] The Board further finds that the Providers appeals are permitted under

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[38] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[39] 201 F. Supp. 3d 131 (D.D.C. 2016).
[40] *Banner* at 142.
[41] CMS Ruling CMS-1727-R at 1-2.
[42] *Id*. at unnumbered page 7.
[43] 42 U.S.C. § 1395oo(a)(l)(B); 42 C.F.R. § 405.1835(a)(3)(ii).
[44] *Compare* 42 U.S.C. § 1395oo(a)(l)(A)(i)-(ii) with § 1395oo(a)(l)(B); see also 79 Fed. Reg. 49,854, 50,199-200 (Aug. 22, 2014) (implementing a "technical correction" "to eliminate provider dissatisfaction as a requirement for Board jurisdiction over appeals based on untimely contractor determinations").
[45] *Id*.
[46] Four providers in 15-3426GC filed from not receiving timely determinations from accepted amended cost report filings.
[47] Under Ruling 1727-R, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no

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

Finally, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000 as required for a group appeal.[48] [49] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount in each case.

Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[50] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[51] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[52] To date, CMS has yet to issue its new final rule.[53]

As the Providers' appeals concern the FY 2008 and 2011 cost reporting periods, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[54] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a

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

[48] *See* 42 C.F.R. § 405.1837.

[49] Although both 18-0948GC and 18-1382GC were established as group appeals, they only have a single participant and the Board is electing to treat the cases as individual appeals. The appeals were timely filed and the $10,000 amount in controversy for an individual appeal has been met by both Providers per 42 C.F.R. § 405.1835(a)(2).

[50] (Emphasis added.)

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

[52] Id. at 2.

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

[54] (Emphasis added.)

"qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

Validity of CMS Ruling 1739-R

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

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[55]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[56] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

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

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

> intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[57]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [58] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[59]

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[60] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

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

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

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

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

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[57] *See Southwest* at 6-7.
[58] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[59] *See* CMS 1739-R at 8.
[60] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

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

For the Board:

<u>Board Members Participating</u>:

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

9/30/2021

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson Leong, FSS
Danelle Decker, National Government Services, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
QRS CHS 2015 DSH Uncompensated Care Distribution Pool Group
Case No. 18-0555GC

Dear Mr. Ravindran,

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

Pertinent Facts:

On January 18, 2018, the Provider filed the CIRP group appeal request (within 180 days of the IPPS Final Rule), appealing CMS' calculations of the pool of uncompensated care ("UCC") payments available for distribution to Disproportionate Share Hospital ("DSH") eligible hospitals as finalized in the 2014 Inpatient Prospective Payment System on August 2, 2013.

The Providers argue that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, specifically, in its calculation of Factors 1 and 2.[1] First, the Providers claim that CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA"). They say that providers had a lack of information during the initial rulemaking for rules regarding UCC payments, and as a result could not submit meaningful commentary on the proposed rules.[2] Second, the Providers state that CMS acted beyond its authority by failing to adhere to the *Allina*[3] decision. They argue that the base year statistic used to calculate the 2014 UCC payments (2011) was understated due to mistreatment of Part C days, and claim that *Allina* required a recalculation of the 2011 data since that case rendered CMS' policy regarding those days "null and void."[4]

The Medicare Contractor filed a Jurisdictional Challenge on June 15, 2018, arguing that the Board's jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g).

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[1] Group Issue Statement at 1.
[2] *Id.* at 1-2.
[3] *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[4] Group Issue Statement at 3.

The Provider's Representative filed a Jurisdictional Response on July 11, 2018 arguing that the applicable statute does not authorize the Secretary to estimate the uninsured patient population percentage; that the Board may review the Secretary's estimates because the federal courts may also conduct such a review; that the provider is entitled to a writ of mandamus directing the Secretary to revise her estimates; and that even if challenges to the estimates are precluded, this does not preclude a challenge to the regulations and policies themselves which underlie the estimates made by the Secretary.

<u>Relevant Law and Analysis</u>:

A. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[5]
>
> (B) Any period selected by the Secretary for such purposes.

B. Interpretation of Bar on Administrative Review

1. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"),[6] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[7] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

[5] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[6] 830 F.3d 515 (D.C. Cir. 2016).
[7] 89 F. Supp. 3d 121 (D.D.C. 2015).

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[8] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[9]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[10]

2. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[11] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[12] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[13]

3. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[14] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care

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[8] 830 F.3d 515, 517.
[9] *Id.* at 519.
[10] *Id.* at 521-22.
[11] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[12] *Id.* at 506.
[13] *Id.* at 507.
[14] 514 F. Supp. 249 (D.D.C. 2021).

that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[15] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[16] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[17] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[18]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[19]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[20] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[21] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express;
> (ii) there is no alternative procedure for review of the statutory

[15] *Id.* at 255-56.
[16] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[17] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[18] *Id.*
[19] *Id.* at 262-64.
[20] *Id.* at 265.
[21] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).

> claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[22]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[23] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

4. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[24] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[25] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[26] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[27] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[28]

Board Decision:

The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2015. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to

[22] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[23] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[24] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[25] *Id.* at *4.
[26] *Id.* at *9.
[27] 139 S. Ct. 1804 (2019).
[28] *Ascension* at *8 (bold italics emphasis added).

administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

Accordingly, the Board dismisses Case No. 18-0555GC and removes it from the Board's docket. The Board notes that its ruling is consistent with the D.C. Circuit's decision in *Tampa General*, *DCH v. Azar*, and *Ascension* and that these decisions are controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[29] Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA

For the Board:

9/30/2021

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Administrators (J-8)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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Quality Reimbursement Services, Inc.
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RE: ***Jurisdictional Decision***
QRS HMA 2015 DSH Uncompensated Care Distribution Pool Group
Case No. 18-0587GC

Dear Mr. Ravindran,

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

Pertinent Facts:

On January 19, 2018, the Provider filed the CIRP group appeal request (within 180 days of the IPPS Final Rule), appealing CMS' calculations of the pool of uncompensated care ("UCC") payments available for distribution to Disproportionate Share Hospital ("DSH") eligible hospitals as finalized in the 2014 Inpatient Prospective Payment System on August 2, 2013.

The Providers argue that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, specifically, in its calculation of Factors 1 and 2.[1] First, the Providers claim that CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA"). They say that providers had a lack of information during the initial rulemaking for rules regarding UCC payments, and as a result could not submit meaningful commentary on the proposed rules.[2] Second, the Providers state that CMS acted beyond its authority by failing to adhere to the *Allina*[3] decision. They argue that the base year statistic used to calculate the 2014 UCC payments (2011) was understated due to mistreatment of Part C days, and claim that *Allina* required a recalculation of the 2011 data since that case rendered CMS' policy regarding those days "null and void."[4]

The Medicare Contractor filed a Jurisdictional Challenge on June 12, 2018, arguing that the Board's jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g).

[1] Group Issue Statement at 1.
[2] *Id.* at 1-2.
[3] *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014).
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The Provider's Representative filed a Jurisdictional Response on July 11, 2018 arguing that the applicable statute does not authorize the Secretary to estimate the uninsured patient population percentage; that the Board may review the Secretary's estimates because the federal courts may also conduct such a review; that the provider is entitled to a writ of mandamus directing the Secretary to revise her estimates; and that even if challenges to the estimates are precluded, this does not preclude a challenge to the regulations and policies themselves which underly the estimates made by the Secretary.

Relevant Law and Analysis:

A. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[5]
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[6] 830 F.3d 515 (D.C. Cir. 2016).
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The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[8] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[9]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[10]

2. DCH Regional Med. Ctr. v. Azar

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[8] 830 F.3d 515, 517.
[9] *Id*. at 519.
[10] *Id*. at 521-22.
[11] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[12] *Id*. at 506.
[13] *Id*. at 507.
[14] 514 F. Supp. 249 (D.D.C. 2021).

that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[15] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[16] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[17] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[18]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[19]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[20] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[21] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express;
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[16] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[17] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[18] *Id.*
[19] *Id.* at 262-64.
[20] *Id.* at 265.
[21] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).

> claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[22]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[23] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

4. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[24] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[25] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[26] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[27] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[28]

<u>Board Decision:</u>

The Board finds that it does not have jurisdiction over the UCC DSH Payment issue in this CIRP group appeal, and hereby dismisses the CIRP group appeal. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2015. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina*

[22] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[23] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[24] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[25] *Id*. at *4.
[26] *Id*. at *9.
[27] 139 S. Ct. 1804 (2019).
[28] *Ascension* at *8 (bold italics emphasis added).

decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

Accordingly, the Board dismisses Case No. 18-0587GC and removes it from the Board's docket. The Board notes that its ruling is consistent with the D.C. Circuit's decision in *Tampa General*, *DCH v. Azar*, and *Ascension* and that these decisions are controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[29] Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA

For the Board:

9/30/2021

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Administrators (J-8)

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