PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D36

PROVIDERS -
Southwest Consulting 2004 DSH Dual Eligible Days Group;
CHI 2004 Dual Eligible Days Group; and
Caritas Christi Health Care 2004 DSH Dual Eligible Days Group

Provider Nos.: Various

vs.

INTERMEDIARIES -
Blue Cross Blue Shield Association/ Wisconsin Physician Services/National Government Services-ME

DATE OF HEARING -
June 1, 2010

Cost Reporting Period Ended -
2004

CASE NOs.: 07-2626G, 06-2111GC and 09-2298GC

INDEX

Page No.

ISSUE:

Should the Provider Reimbursement Review Board grant the Providers' request for expedited judicial review (EJR) over the validity of the provisions of the Centers for Medicare & Medicaid Services Ruling CMS-1498-R, which if valid, render moot and deny jurisdiction over the dual-eligible group appeals?[1]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

The underlying issue in dispute in these cases involves the proper amount of Medicare reimbursement due providers of medical services. The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (HHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and interpretive guidelines published by CMS. 42 U.S.C. §1395h; 42 C.F.R. §§413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) provided it meets the following conditions: (1) The provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy for a single provider must exceed $10,000 for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination. 42 U.S.C. §1395oo(a); 42 C.F.R. §§405.1835-405.1837.

The Medicare statute at 42 U.S.C. §1395oo(f)(1) and the regulations at 42 C.F.R. §405.1842(f)(1) (2008) require the Board 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.

Medicare Disproportionate Share Hospital (DSH) Payment

Part A of the Medicare Act covers "inpatient hospital services." 42 U.S.C. §1395d(a)(1). Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system (PPS). 42 U.S.C. §§1395ww(d)(1)-(5); 42

[1] In case number 07-2626G, the Southwest Consulting 2004 DSH Dual Eligible Days Group, this decision applies to only those cost reporting periods/portions of cost reporting periods involving discharges before October 1, 2004.

C.F.R. Part 412. Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments. Id.

One of the PPS payment adjustments is the DSH payment adjustment. The Secretary is required to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. §1395ww(d)(5)(F)(i)(I); 42 C.F.R. §412.106. Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends on the hospital's "disproportionate patient percentage" (DPP). 42 U.S.C. §1395ww(d)(5)(F)(v).

The DPP is defined as the sum of two fractions expressed as a percentage. 42 U.S.C. §1395ww(d)(5)(F)(vi). Both of these fractions look, in part, to whether the hospital's patients for such days claimed during the particular cost reporting period were "entitled to benefits" under Medicare Part A.

The first fraction used to compute the DSH payment is commonly known as the Medicare fraction. It is also referred to as the SSI fraction because the numerator is determined by the number of patient days for which the patient was entitled to Supplemental Security Income (SSI). The statute defines the SSI fraction as:

> (I) 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 …

42 U.S.C. §1395ww(d)(5)(F)(vi)(I) (emphasis added).

The SSI fraction is computed annually by CMS, and the Medicare fiscal intermediaries are required to use CMS' calculation to compute a hospital's DSH payment adjustment. 42 C.F.R. §412.106(b)(2)-(3).

The second fraction used to compute the DSH payment is the Medicaid fraction, defined as:

> (II) 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 of this chapter, 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.

42 U.S.C. §1395ww(d)(5)(F)(vi)(II) (emphasis added).

According to CMS' regulation, "[t]he fiscal intermediary 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." 42 C.F.R. §412.106(b)(4).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The common issue presented in these group appeals concerns the treatment of inpatient days for patients who were enrolled in both Medicaid and Medicare Part A in the DSH payment calculation. Although all of the patients in question were enrolled in Medicare Part A when they were treated by the hospital, none of them had Medicare Part A payments made on their behalf for the particular inpatient hospital days at issue, either because the patient had exhausted his or her Medicare Part A benefits for the inpatient hospital services furnished during a given spell of illness (exhausted benefit days) or because another party with liability primary to Medicare's made payment for the days (MSP days). These patient days are referred to collectively as "dual eligible" days.[2] The dispute in these group appeals involves which of the two DSH fractions these dual eligible days should be included.

The Board conducted a concurrent hearing on this matter for multiple group cases on March 31, 2010, where the parties agreed the dispositive legal issue is whether these patients were "entitled to benefits" under Part A of the Medicare statute for the dual eligible inpatient days at issue. The Providers assert that the statute, regulations, and Agency policy and practice compel a finding that these patient days are to be included in the numerator of the "Medicaid fraction" that is used to calculate the DSH payment.[3]

Subsequently, on April 28, 2010, CMS issued Ruling No: CMS-1498-R (Ruling). Rulings are decisions of the Administrator that serve as "precedent final opinions or orders or statements of policy or interpretation" and are binding on all CMS components, on all HHS components that adjudicate matters under the jurisdiction of CMS.[4] The Board is one of these adjudicatory bodies. CMS-1498-R deals with the DSH treatment for two types of patient days: (1) non-covered inpatient hospital days for patients entitled to Medicare Part A, and days for which patient's Part A inpatient hospital benefits are exhausted (referred to as dual eligible days); and (2) labor/delivery room inpatient days.[5] It also requires a change in the data match process used in the calculation of the SSI fraction.[6] These cases involve only the Ruling's directives as to non-covered dual eligible days.

On May 13, 2010, the Providers filed a request for EJR challenging the validity of the Ruling which, if valid, purports to render moot and deny the Board's jurisdiction to decide the appeals

[2] Provider's Position Paper at 1-2.
[3] Id. at 2.
[4] Ruling at 1.
[5] Id. at 7 and 15.
[6] Id. at 4.

heard on March 31, 2010. On June 1, 2010, the Board heard oral arguments. CMS' representative presented the Agency's position.

The Providers were represented by Christopher Keough, Esq. of King and Spalding, Washington, D.C. The Intermediaries were represented by Arthur Peabody, Jr., Esq. of Blue Cross Blue Shield Association. CMS was represented by Mark Polston, Esq. of the Office of General Counsel.

DECISION OF THE BOARD

For the reasons stated below, the Board concludes that EJR is appropriate to determine the validity of those provisions in the Ruling that would, if valid, deprive the Board of jurisdiction and thereby prohibit it from granting EJR as to the validity of other substantive provisions of the Ruling.

42 U.S.C. §1395oo(a) establishes the Board's jurisdiction. It provides in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board … if –
>
> (1) such provider
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report …

The Board determined that the Providers met the jurisdictional requirements for a right to hearing under 42 U.S.C §1395oo(a) and conducted a hearing on the merits on March 31, 2010. However, subsequent to the hearing, CMS issued Ruling No.: CMS-1498-R (Ruling). The Ruling states that it "eliminates any actual case or controversy regarding the hospital's previously calculated DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal … in which the hospital seeks inclusion in the DPP of the non-covered inpatient hospital days … or exhausted benefit inpatient hospital days of a person entitled to Part A."[7] "[I]t is hereby held that the PRRB … lack[s] jurisdiction over each properly pending claim [on the dual eligible issue] … provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements for appeal."[8] In substance, the Ruling makes a determination that dual eligible days are to be counted in the SSI fraction -- the opposite of what Providers claim in these appeals is required by the statute, the regulation, and prior CMS policy.

[7] Ruling at 12.
[8] Id.

Procedurally, it requires the Board to terminate further action[9] on these cases and remand them to the Intermediary for a recalculation of the DSH payment adjustment.

The Providers challenge the validity of the Ruling for a multitude of reasons,[10] among them: it counts dual eligible days in the SSI fraction which Providers allege is forbidden by statute and regulation; it denies their placement in the Medicaid fraction, even though the statute and regulation mandate their placement in the Medicaid fraction; it violates the Medicare Act and Administrative Procedures Act (APA) in that it changes a substantive standard for payment without notice and comment and is impermissibly retroactive; and it attempts to divest the Board of jurisdiction in violation of the Medicare Act.

The Providers' challenge to the substantive and procedural validity of the Ruling is the classic situation for which EJR authority was designed. 42 U.S.C. §1395oo(f)(1) provides 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. Congress' intent in enacting the EJR provision was to avoid the delay in resolution of controversies for extended periods of time while providers are forced to pursue "a time-consuming and irrelevant administrative review merely to have the right to bring suit in a U.S. district court." H.R. Rep. 96-1167, 394, 1980 U.S.C.C.A.N. 5526, 5757. See also Tallahassee Memorial Reg. Med. v. Bowen, 815 F.2d 1435 (11th Cir. 1987) (the intent of the EJR was to "end pointless administrative litigation.").

CMS agrees with the Providers' assertion that the Board has no authority to decide the validity of the Ruling.[11] In that the parties agree that this dispute satisfies the second prong of the EJR requirement that the legal question is beyond the Board's authority to decide, the Board agrees with CMS' assertion that the EJR dispute now centers solely on whether the Board has jurisdiction to grant EJR.[12] As will be discussed below, this dispute implicates various facets of Board jurisdiction and the Board is in the precarious position of violating a statute, regulation, or ruling regardless of how it ultimately resolves this dispute.

The problem presented in the 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

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[9] Board action is terminated except for a determination whether the cases involve issues subject to the Ruling and whether the providers meet the jurisdictional requirements of 42 U.S.C. §1395oo(a).

[10] As the Agency's position developed through its response to the Providers' EJR request and oral argument, other challenges to the Ruling's validity arose. For example, CMS argued the Ruling in effect 'vacated' the prior intermediary final determination under the authority of 42 C.F.R. §405.1875. Tr. at 82. The Providers responded that the regulation only permits vacating a final decision of the Board. See e.g. Tr. at 43. The Providers also argued the action is, in effect, a reopening under 42 C.F.R. §405.1885 in violation of the regulation's three year time limitation. Tr. at 189.

[11] Tr. at 92.

[12] Tr. at 79-80.

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.

The Providers contend the Board has jurisdiction to determine its own jurisdiction even if it ultimately finds the Ruling deprives it of jurisdiction.[13] CMS agrees.[14] Citing Supreme Court precedent, the Providers further argue that the Board has inherent authority to issue orders necessary to preserve the status quo while jurisdiction is determined.[15] The application to this matter, the Providers argue, is that the Board has the power to preserve the status quo by granting EJR for the Federal courts to determine the validity of the Ruling's provisions that purport to deprive the Board of jurisdiction.[16]

Pursuant to the legal principles established by the Supreme Court cases cited and, as explained more fully below, the Board finds that EJR is appropriate to the extent necessary to determine whether the Ruling validly removes the Board's jurisdiction.

CMS asserts that the fundamental jurisdictional requirements must be met at every stage of the proceeding: " 'an actual controversy must be extant at all stages of review, not merely at the time the complaint is filed.' "[17] CMS further explains that the action required by the Ruling has the effect of vacating the previously issued Medicare payment determination.[18] The final payment determinations having been vacated, CMS contends the fundamental requirement for jurisdiction under the statute "no longer exist[s] because the CMS Administrator admitted liability and vacated the final payment determinations in this case."[19] CMS also contends that without a new final payment determination, it is impossible to determine the reimbursement impact of the Ruling, thus raising a second jurisdictional impediment: the amount in controversy, if any, cannot be determined.[20]

CMS also argues that EJR cannot be granted until all factual disputes are resolved in the administrative process,[21] and that the amount in controversy constitutes a factual dispute that cannot be quantified until a new payment determination is made. Under these circumstances, CMS advises that the Board is bound by regulation to follow the Ruling and must remand which will in turn cure the jurisdictional impediments by producing a new final payment determination and resolve the factual question as to the precise financial impact. The Providers respond that neither the EJR statutory provisions nor the regulations require disposition of factual disputes as

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[13] Tr. at 77.
[14] Tr. at 78.
[15] U. S. v. Ruiz, 536 U.S. 622, 627-28 (2002) (Provider's Legal Authorities, Tab 7); U.S. v. United Mine Workers, 330 U.S. 258 (1947) (Provider's Legal Authorities, Tab 8) ; See also Tr. at. 20-29.
[16] Tr. at 29.
[17] Intermediary's May 28, 2010 Comments on Providers' Request for [EJR] at 5.
[18] Tr. at 82 and 84.
[19] Tr. at 85.
[20] Intermediary's May 28, 2010 Comments on Providers' Request for [EJR] at 5-6.
[21] Id. at 9

a condition precedent to EJR[22] but, even if it were required, the hearing record is sufficient to resolve the fact issue. The Providers also challenge the factual and legal premise that the Ruling "resolves" the claim raised in these cases and therefore moots the controversy.

Mootness: Whether the Controversy Has Been Eliminated

The first premise on which CMS relies to deprive the Board of jurisdiction is that the dispute has been resolved, thus eliminating the "case or controversy" requirement for jurisdiction. Within the context of the Medicare Act, the case or controversy arises from "dissatisfaction" with a "final determination." 42 U.S.C. §1395oo(a). The final determination is typically an NPR issued by the Intermediary which calculates the total program reimbursement due and explains the difference between the amount claimed by the Provider and the amount found allowable by the Intermediary.[23] It includes the DSH payment percentage calculated using data supplied solely by CMS for some components and data supplied by the provider or the State for other components.

The crux of the Providers' appeal is that the statute, regulation, and prior policy of CMS require the dual eligible days in question to be counted in the Medicaid fraction, and forbids their inclusion in the SSI fraction. It is undisputable that the Ruling mandates that these dual eligible days be counted in the SSI fraction,[24] despite acknowledging that the regulation in effect in the relevant time frame prohibited their inclusion.[25] CMS explains its "acquiescence to liability," on which it asserts that the Providers' claim is now resolved and moot, as follows:

> In that Ruling, the CMS Administrator has resolved issues associated with these appeals here as well as all other similar appeals that fall into the category of providers who seek to have the . . . inpatient days of individuals who are dually eligible for both Medicaid and Medicare . . . counted *some place* in the DSH payment calculation. The CMS Administrator acquiesced to liability in those matters. The policy that the CMS Administrator had prior to that was, frankly, legally untenable. Those days were not counted in the SSI fraction nor were they counted in the Medicaid fraction. . . . [26] These are obviously inpatient days which need to be counted in the DSH calculation *some place*, and by action of 1498-R the CMS Administrator concedes liability on that count. (Emphasis added)

Tr. at 81-82.

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[22] Prior to August 2008, the EJR regulation required a finding that there were no material facts in dispute. When the regulations were modified, that provision was eliminated and only the two requirements set out in the statute were included in the new regulation at 42 C.F.R § 405.1842.

[23] See 42 C.F.R. §405.1803(a)(2).
[24] Ruling at 8-14.
[25] Id. at 8.
[26] Some discussion is omitted here relating to Providers assertion and evidence presented by the Declaration of David Pfiel that CMS and the intermediaries did knowingly count the days in the Medicaid fraction prior to 2004.

Upon questioning by the Board as to how the Ruling could be interpreted as an acquiescence to the Providers' position, CMS insisted that the Ruling's directive to count the dual eligible days in the SSI fraction was an acquiescence to the Providers' claim in these cases that the Medicare Act prohibited counting the days in the SSI fraction and compelled their inclusion in the Medicaid fraction. CMS' representative explained as follows:

> Yes, I can seriously say that [there is acquiescence to the Providers' position.] Let me give you an example. And this has happened in the past. The Board can write an opinion saying these days were not counted – these days need to be counted in the Medicaid fraction. Let's say that was the final decision of the Board. We could – then let's say further that the Administrator determined that these days are not appropriately counted in the Medicaid fraction. In theory, we could defend that decision because they're not to be counted in the Medicaid fraction. Why we settled those matters is because they were not in the SSI fraction either. So, yes, we actually are acquiescing. It's a meaningful acquiescence ….

Tr. 231-232.

Apparently anticipating a response from the Providers, as here, that the "resolution" of the particular dispute, thereby eliminating any case or controversy and rendering the claim moot, is a fiction,[27] the Ruling acknowledges that providers "might seek … to include non-covered or exhausted … days in the numerator of the Medicaid fraction instead of in the SSI fraction." The Ruling instructs that the Board "should remand … regardless" of whether the hospital seeks to include the days in the Medicaid rather than the SSI fraction. (emphasis added) It reasons that the providers may be satisfied with the outcome but, if not, *then* they can appeal, and "have [their] day in court eventually" including challenging the validity of the Ruling via EJR.[28]

The Providers counter that CMS' declaration of "mootness" contravenes well established legal principles, citing Tucson Medical Center et al. v. Sullivan, 947 F.2d 971, 978 (D.C. Cir. 1991) (applying the rule that "as long as the parties have a concrete interest, however small, in the outcome of the litigation, the case is not moot") (quoting Elis v. Brotherhood of Ry. Airline & SS Clerks, 466 U.S. 435, 442 (1984)); Ramer v. Saxbe, 522 F. 2d 695, 704 (D.C. Cir. 1975) ("A case is not moot so long as any single claim for relief remains viable whether that claim was the primary or secondary relief originally sought.").[29] The Providers also point out that the two courts that have ruled on the matter found CMS' position inconsistent with the statute, citing Northeast Hospital v. Sebelius, 2010 WL 1199311 (D.D.C. 2010) and Metropolitan Hospital v. Department of Health and Human Services, 2010 WL 1379600 (W.D. Mich. 2010). These decisions further indicate that the legal dispute is in fact a live controversy.[30]

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[27] See e.g. Tr. at 56-59.
[28] Tr. at 79.
[29] See also Tr. 39-44 regarding whether this dispute is one that is "capable of repetition yet evading review."
[30] EJR Request at 2; Tr. at 55-56.

The Board can find no factual justification for the Ruling's factual premise that a claim asserting that the statute and regulation compels inclusion in the Medicaid fraction and prohibits inclusion in the SSI fraction is moot because CMS has determined to do the opposite. Even though the Board does not have authority over the validity of the Ruling, the factual premise regarding mootness is the very foundation for CMS' position that the Board lacks jurisdiction.[31] Having found the factual basis on which CMS relies to be faulty, the question nevertheless remains whether, as CMS appears to argue,[32] the Ruling's mere *declaration* that the claim is moot makes it so and consequently does deprive the Board of jurisdiction which otherwise exists under 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-405.1837.

Amount in Controversy

Similarly, the Ruling challenges a second prong of the Board's jurisdiction under 42 U.S.C. §1395oo(a) saying that the Board can no longer determine that the amount in controversy is satisfied. CMS explains that because the Ruling requires a new DSH determination, the Providers have no basis on which to claim they will suffer *any* injury, much less whether the injury satisfies the $50,000 aggregate amount in controversy requirement for a group appeal.[33] CMS argued that any assertion of the amount of the impact would be a "guess" [34] without a new determination that will also include changes based on two other DSH changes required by the Ruling. CMS asserts that whether or not a provider will be dissatisfied after the recalculation is "only speculation."[35]

In connection with the hearing on the merits, the Providers furnished calculations of the impact of the Intermediaries' adjustments disallowing their counting the days claimed in the Medicaid fraction.[36] The Providers acknowledge that the impact will change upon recalculation under the Ruling but contend the amount in controversy will still well exceed the jurisdictional amount and, in most cases will increase.[37]

The Providers also complain that their opportunity to challenge any element of the SSI percentage calculation is severely impeded by CMS' refusal to make source data available for what goes into the calculation. To demonstrate their assertion that the "swing" from counting the days in the SSI fraction (which they contend will decrease the fraction) to including them in the Medicaid fraction (which they contend will increase that component), the Providers relied on data for one year, 2005, that CMS had furnished for 52 hospitals, though not necessarily the

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[31] In oral argument on the propriety of EJR, CMS argued that the Ruling shows the CMS Administrator "acquiesced to liability in those matters" where providers seek to have the dual eligible days counted "*some place* in the DSH payment calculation." (emphasis added) Tr. at 80-81, 85. CMS cites 42 C.F.R. §405.1875(f)(2) as authority for the Administrator's action, saying "[n]o one questions the CMS Administrator's authority . . . to remand the case back to either the contractor or back to the Board for further factual development or for application of a rule or a statute or even a ruling that was not considered by the Board or was not considered by the fiscal intermediary."

[32] See e.g. Tr. at 197. CMS' representative states "The Administrator has decided that the Board no longer has jurisdiction. That's the answer to the question."

[33] Intermediary's May 28, 2010 Comments on Request for [EJR] at 5-6, 9-10.

[34] Tr. at 98.

[35] Intermediary's May 28, 2010 Comments at 8.

[36] The relevant documents as to the cases in this EJR request are Providers' Hearing Exhibits 3, 5 and 19 and Schedule of Providers, Tab E, for each of the three group cases.

[37] Tr. at 52.

hospitals involved in this appeal.[38] The Providers advise they are limited to using this data to calculate the difference between the two approaches because CMS then imposed a moratorium[39] on furnishing any further source data. As a result of its analysis of the 2005 data, the Providers believe the SSI fraction includes the change to include the days of dual eligible beneficiaries whose days were non-covered because the regulation had been revised effective in 2004 to implement that change in CMS policy.[40] In its EJR request, the Providers filed a Declaration of David Pfiel, the Providers' consultant, in which he analyzed the difference in placing the days in one fraction or the other for the 52 hospitals. He concluded that in 94% of the cases analyzed, the SSI fraction would be diluted, which would result in an average loss per hospital of $49,000 per cost reporting period. However, inclusion in the Medicaid fraction, as the Providers claim is required by the statute, would increase the DSH calculation for every hospital by an average of $95,000, a total impact of $144,000 on average.[41] After questions regarding the calculations were raised by the Intermediary, the Declaration was supplemented by agreement of the parties. Mr. Pfiel concluded that, based on the additional considerations, the impact – and therefore the amount in controversy – of counting the days in the SSI fraction instead of the Medicaid fraction (referred to as the "swing") was a loss of $157,000 (as compared to $144,000) on average per hospital, per cost reporting year.[42]

The Providers also point out that CMS has not furnished any evidence to dispute their assertion they will be harmed by counting the days in the SSI fraction even though CMS "has at its disposal today all the evidence for all the years for all these Providers and every other one in the country that they could tell you in no certain [sic] terms what the effect is of adding Part A exhausted and MSP days to the SSI fraction,"[43] and that evidence from a prior case that, in part, prompted the Ruling established that CMS could easily and quickly produce the data.[44] Given CMS' refusal to make source data available, the Providers argue that, even if a new DSH calculation is made on remand, hospitals will still have to use their own data as the best available to calculate the impact of counting the days in one fraction or the other in order to show they meet the amount in controversy. They will not be able to achieve the "precise" impact to establish the "concrete setting" CMS alleges is "necessary for eventual review by the Board, the Administrator or the Federal court." [45]

The Board finds the evidence sufficient to show that, if the Providers prevailed on their substantive claim, the recovery would likely substantially exceed the jurisdictional amount. But, as the amount in controversy is a fundamental requirement for Board jurisdiction, the question remains whether the Ruling's declaration that an amount in controversy cannot be shown requires the Board to take it as an established fact.

Mootness and amount in controversy are the underpinnings for the Ruling's premise that the Board lost jurisdiction; however, those concepts are imbedded in the substantive provisions of

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[38] Tr. at 47-48.
[39] Providers contend this is public information, available on CMS' website. CMS did not dispute the assertion.
[40] Tr. at 44-49.
[41] Pfeil Declaration June 4, 2010, at ¶ 17; Tr. at 75, 122-123.
[42] Pfiel Declaration, June 4, 2010, at ¶¶ 2-8.
[43] Tr. at 46.
[44] Tr. at 46-47.
[45] Intermediary's May 28, 2010 Response to [EJR] at 9; Tr. at 101.

the Ruling as to the treatment of dual eligible days. Because the Board lacks authority to invalidate any part of the Ruling, and because it is the Ruling that purports to deprive the Board of its jurisdiction, the Board finds it lacks the authority to make a determination of whether it continues to have jurisdiction necessary to grant EJR. However, it is undisputed that the Board has jurisdiction over the parties and the subject matter; therefore the Board concludes EJR will maintain the status quo by preserving the parties' position in the administrative process. Then the question of the Board's jurisdiction can be determined by the Federal court, the only adjudicative body with authority to invalidate the challenged provisions of the Ruling that deprive the Board of jurisdiction. The Board finds that EJR to determine the validity of the Ruling as to jurisdiction is the only "orderly and proper proceeding"[46] available to it in these circumstances where jurisdiction is in doubt.

If the Federal court concludes the Board does not have jurisdiction, (or even if the Board had concluded on its own that the CMS position was valid and that it lacked jurisdiction under the dictates of the Ruling), then another conflict arises between the regulation and the Ruling as to the Board's authority to impose a remedy. The Ruling provides the Board must remand as a result of no longer having jurisdiction (because the final determination on which jurisdiction is based has been vacated and, thus, the dispute is rendered moot, or the requisite amount in controversy cannot be satisfied). However, the regulation at 42 C.F.R. §405.1840 entitled "Board jurisdiction" at subsection (c)(2) provides "[W]here the Board determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a dismissal decision dismissing the appeal for lack of Board jurisdiction." Consequently, as to remedy alone, if jurisdiction is lacking and the Board remands the case, it violates the regulation. At the same time, if, as required by the regulation, it dismisses the case, the Board violates the Ruling. The regulation and Ruling therefore pose an irreconcilable conflict, the resolution of which is outside the Board's authority to resolve and is appropriate for EJR.

CMS advised it was "compelled to point out that obviously there's an Administrator's review of the jurisdictional basis for EJR" so "there's a fairly likely scenario [in] which the Administrator decides that there would be no jurisdictional basis here [for EJR]." This position demonstrates another irreconcilable conflict that, given CMS' statement, will inevitably be implicated in this matter and which is beyond the Board's authority to decide. The EJR statute provides that the Board's EJR decision is "not subject to review by the Secretary." 42 U.S.C. §1395oo(f)(1). The legislative history states that the EJR provision "addresses the problem [of delay in the resolution of controversies for extended periods of time and to require providers to pursue a time consuming and irrelevant administrative review merely to have the right to bring suit in a U.S. district court] by giving Medicare providers the right to obtain *immediate* judicial review in instances where the Board determines that it lacks jurisdiction to grant the relief sought." (emphasis added) H.R. Rep. 96-1167, 394, 1980 U.S.C.C.A.N. 5526, 5757. The statute and regulations require the Provider to file suit within 60 days of the Board's EJR decision. However, the regulations at 42 C.F.R. §§405.1842(a)(3) and (g)(1)(i)-(iii) provide that the Administrator can review the jurisdiction component of the Board's EJR determination, that the Board's EJR determination is "inoperative" during the 60 day period of review by the Administrator (the same 60 day period the provider has in which to file suit) and, unless the Administrator affirms the Board's determination on jurisdiction, it is non-final and the provider

[46] U.S. v. United Mine Workers, supra at 293.

has no right to judicial review. 42 C.F.R. §405.1842(g)(2). These conflicting provisions create a conundrum the Board is unable to unravel without the aid of a Federal court because it cannot invalidate any of these challenged provisions.

CMS also urges the Board to consider the following principles behind administrative exhaustion[47] as supporting the Ruling's requirement for remand:

(1) To avoid premature interruption of the administrative process;
(2) To let the agency develop the necessary factual background upon which decisions should be based;
(3) To permit the agency to exercise discretion or apply its expertise;
(4) To improve the efficiency of the administrative process;
(5) To conserve scarce judicial resources, since the complaining party may be successful in vindicating rights in the administrative process and the courts may never have to intervene;
(6) To give the agency a chance to discover and correct its own errors; and
(7) To avoid the possibility that "frequent and deliberate flouting of the administrative process could weaken the effectiveness of an agency by encouraging people to ignore its procedures."

CMS avers that application of these principles to require starting administrative proceedings anew will achieve these goals because further proceedings would: (1) permit a determination of the precise impact of the Ruling versus the relief Providers claim is required by the statute; and (2) some providers may be satisfied with the result and have no desire to pursue an appeal further.[48]

As discussed above, a redetermination will not produce the "precise impact" of the dueling positions as long as CMS refuses to make source data available despite there being authority already in place requiring it to be furnished. Therefore, requiring further exhaustion to develop the particular factual background CMS alleges is necessary will still fail. While there is a possibility that some providers may decide to abandon appeals, Providers explain it may have little to do with "satisfaction" with the redetermination under the Ruling but rather because Providers are presented with a "Hobson's choice:" They could run the risk of having their DSH payment adjustment lowered on application of the Ruling and consequently have potentially thousands of dollars recouped while they again work their way through the administrative process to Federal court where they could finally attack the validity of the Ruling -- or they could forever forfeit their long-pending claims. EJR Request at 8.

In that CMS has invited the Board to consider these general exhaustion principles, the Board finds other exhaustion principles CMS enumerated are also frustrated rather than fostered by the Ruling. For example, the Board fails to appreciate how requiring Providers in this particular dispute to start over in the administrative process at this stage would conserve judicial resources under the premise some providers might be successful or it might result in the agency

[47] CMS cites Nicholas v. Board of Trustees of Asbestos Workers Local 24 Pension Plan, 725 F. Supp. 568, 571 (D.D.C. 1989)(citations omitted); Intermediary's May 28, 2010 Comments on Providers' Request for [EJR] at 9.
[48] Intermediary's May 28, 2010 Comments on Providers Request for [EJR] at 9.

discovering and correcting its errors. The battle over which component of DSH is appropriate for counting dual eligible days has been fought for years during which CMS has admittedly changed its position. The Ruling is the most recent determination by CMS on how the days in dispute will be counted. However, that determination is precisely the opposite of what Providers claim is required and what two Federal courts have found impermissible under the statute. This indicates CMS has already fully considered and firmly rejected the Providers' position and is equally unconvinced by the decisions of the Federal district courts. Given this history, it is clear the resolution of this issue is destined to be made in the Federal appellate courts which will only be delayed by requiring exhaustion of another administrative process. Moreover, with two Federal district courts having ruled CMS' position to be in violation of the statute, there is a very real prospect that CMS, its intermediaries and providers could invest extensive resources and time to process thousands of recalculations under the Ruling only to have to redo them should the opinions of those two courts prove to the be the prevailing view.

There is not so much as an assertion that the Providers have flouted the administrative process. On the contrary, they have followed it to the letter, likely at substantial expense, including having their attempts to obtain data via a CMS-established method prove unsuccessful, but which CMS now says is essential for jurisdiction.[49] On the other hand, the Ruling, as applied to these cases, is the quintessential interruption of the administrative process.

In summary, the Board concludes as follows:

(1) The Providers' appeals are properly pending before the Board, because, as the Ruling requires us to determine, they "satisfy the applicable jurisdictional and procedural requirements of section 1878 of the Act"[50] [42 US.C. §1395oo(a)] in that the Providers timely filed from a final intermediary determination, they demonstrated their dissatisfaction with that determination, and the financial injury alleged under the Providers' theory of the case satisfies the $50,000 aggregate amount in controversy required for group appeals;

(2) The Board lacks authority to make a determination whether the Ruling deprives it of continuing jurisdiction because the challenged substantive provisions of the Ruling are also the foundation for CMS' claim the Board lacks jurisdiction to grant EJR. The Board has no authority to invalidate any provision of the Ruling; EJR is, therefore, appropriate for the Federal Court to make the determination in that EJR preserves the status quo and aids the Board's determining its own jurisdiction.

(3) If the Federal court finds the terms of the Ruling invalid as to the Board's continuing jurisdiction to grant EJR, then CMS does not dispute that the Board lacks authority to decide the other legal questions raised as to the validity of the Ruling and EJR is appropriate as to those questions as well without further action by the Board.

[49] Providers' consultants assert they have over 500 requests pending or waiting to be filed when CMS lifts its moratorium. See, Providers' May 13, 2010 Request for [EJR], Tab 2, Declaration of David Pfiel at ¶ 12.
[50] Ruling at 18.

(4) The Board lacks authority to make a determination, and concludes that EJR is also appropriate to determine whether the regulatory provisions at 42 C.F.R. §§405.1842(a)(3) and (g)(1)(i)-(iii) are valid

(a) that provide for suspension of the Providers' right to file a Federal court action during the 60 days following a Board determination that EJR is appropriate; and

(b) that prohibit judicial review upon the Administrator's reversing, modifying or remanding the Board's jurisdictional determination on EJR and declaring it non-final.

(5) If the Federal court finds the Ruling valid as to its provisions on the Board's loss of jurisdiction, EJR is appropriate to determine whether the Board is required to dismiss under the regulation or remand under the Ruling.

The Providers have 60 days from the receipt of this letter to institute the appropriate action for judicial review. These cases will remain open pending the decision by the Federal court on the question of the Board's jurisdiction over the appeals.

Board Members Participating

Suzanne Cochran, Esq.
Yvette C. Hayes
Keith E. Braganza, CPA
John Gary Bowers, CPA

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

Attached: Schedule of Providers, 42 U.S.C. § 1395oo (f)

Date: June 14, 2010