PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D48

PROVIDERS -
Southwest Consulting DSH SSI Group Appeals - Consolidated Pilot Project
Provider Nos.: Various

vs.

INTERMEDIARIES -
Blue Cross Blue Shield Association/ Wisconsin Physician Services

DATE OF HEARING -August 31, 2010

Fiscal Years 1998-2006

CASE NOs.: 07-2228G, 07-2201G, 07-2199G, 07-1684G, 07-2802G, 07-0505G, 07-2282G, 09-0551GC, 09-0021GC, 09-0066GC, 09-0067GC, 07-2148G, 07-2364G, 08-0405G, 07-2688G, 09-0526GC, 08-0075G, 09-0765GC

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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 these appeals of the disproportionate share adjustment (DSH) supplemental security income (SSI) issue?

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 and Medicare administrative contractors. 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) if it meets the following conditions: (1) The provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy 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

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 or not 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 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's 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 CMS' calculation of the SSI fraction that was used to determine the Providers' eligibility for, and the amount of the Medicare DSH payment.

On April 28, 2010, CMS issued Ruling No. 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, and on all HHS components that adjudicate matters under the jurisdiction of CMS. See 42 C.F.R. § 401.108. The Board is one of these adjudicatory bodies.

The Ruling applies to three issues in jurisdictionally proper pending appeals concerning the calculation of the Medicare DSH payment: i) the "data matching process" used to calculate the SSI fraction; ii) certain "non-covered" days (further described below) for cost reporting periods beginning before October 1, 2004; and iii) labor and delivery days for cost reporting periods beginning before October 1, 2009. The Ruling purports to render moot and require the Board to remand all appeals on any of these three issues to the Medicare contractors for recalculation of the SSI fraction.

With respect to the SSI "data matching process" issue, which is contested in each of these group appeals, the Ruling provides for recalculation of the SSI fractions on remand to the contractors.[1] The Ruling states that the revised SSI fractions will be calculated by CMS "us[ing] the same revised data matching process as the agency used to implement the *Baystate* decision." [2] See Baystate Med. Ctr. v. Leavitt, 545 F. Supp. 2d 20, amended by 587 F. Supp. 2d 37 (D.D.C. 2008).

However, the Ruling requires CMS to include in the revised SSI fractions the hospital patient days for all patients who were enrolled in Medicare Part A, regardless of whether Medicare Part A benefits were paid for those patient days.[3] As described in the Ruling, this would include a hospital's patient days for individuals who were enrolled in Medicare Part A but had exhausted Part A benefits for inpatient hospital services ("Part A exhausted benefit days") and days that were not paid by Medicare Part A because Medicare's payment liability was secondary to another payor's primary liability ("MSP days").

The Ruling does not expressly apply to, or require remand of, pending appeals on Medicare Part C days for patients who were receiving Medicare benefits under Part C of the Medicare statute through enrollment in a Medicare+Choice or Medicare Advantage plan. The Providers believe that CMS, nevertheless, intends to add those days to the SSI fractions that would be recalculated

[1] CMS Ruling No. 1498-R at 4-7 and 29-30.
[2] Id. at 6, 7, 29-30.
[3] Id. at 7-14 and 29-30.

on remand pursuant to the Ruling, at least for some of the later fiscal years at issue in these cases. The Ruling itself defines the SSI fraction to include days for patients "who are enrolled in a Medicare Advantage (Part C) plan." This follows the agency's stated change in policy, in 2004, to begin counting Part C days in the SSI fraction effective for discharges on or after October 1, 2004. See 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004). The Providers have presented unrebutted evidence showing that, even after that policy change, CMS did not count Part C days in the SSI fractions that CMS calculated for federal fiscal years 2005 and 2006. The Providers now believe that CMS intends to include Part C days in revised SSI fractions that would be recalculated upon remand, pursuant to the Ruling, for at least some of the fiscal years at issue here (2005 and 2006). The Ruling notes that Part C days will be included in the SSI fraction "only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient." [4]

On August 24, 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 these appeals. 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 this matter for these cases on August 31, 2010. The Providers assert that the statute, regulations, policy and practice compel a finding that dual eligible and Medicare Part C patient days may not be included in the SSI fraction and must be included in the numerator of the "Medicaid fraction" that is used to calculate the DSH payment.

The Providers were represented by Christopher Keough, Esq. and J. Harold Richards, Esq. of King and Spalding, Washington, D.C. The Intermediaries[5] were represented by Arthur Peabody, Jr., Esq. of BlueCross BlueShield Association.

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

[4] Id. at 8.
[5] There are multiple Intermediaries involved in these appeals. All Intermediaries agreed to be represented by the BlueCross BlueShield Association, therefore, in the decision, the Intermediaries are referred to as Intermediary.

> the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report …

The Ruling states that it:

> Eliminates any actual case or controversy regarding the hospital's previously calculated SSI fraction and DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal involving the hospital's previously calculated SSI fraction and the process by which CMS matches Medicare and SSI eligibility data. . . . [I]t is hereby held that the PRRB . . . lack[s] jurisdiction over each properly pending claim on the SSI fraction data matching process issue, provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements for appeal."

Ruling at 6.

In substance, the Ruling makes a determination that Part A exhausted and MSP days are to be counted in the SSI fraction for periods prior to October 1, 2004, and strongly suggests that Medicare Part C days will also be included in the SSI fraction on remand, for periods on or after October 1, 2004. This is the opposite of what the Providers claim in these appeals is required by the statute, the regulation, and prior CMS policy. Procedurally, the Ruling requires the Board to terminate further action 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, among them: it counts Part A exhausted, MSP, and Medicare Part C 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 delays 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. Ctr. v. Bowen, 815 F.2d 1435 (11th Cir. 1987) (the intent of the EJR was to "end pointless administrative litigation.").

The Intermediary agrees with the Providers' assertion that the Board has no authority to decide the validity of the Ruling. 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 finds that the EJR dispute in this case centers solely on whether the Board has jurisdiction to grant EJR. 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 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. 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.[6] 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.

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.

The Intermediary 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.' "[7] The Intermediary further contends that the action required by the Ruling has the effect of vacating the previously issued Medicare payment determination. The final payment determinations having been vacated, the Intermediary contends that "there is no longer a 'final determination' of the intermediary -- the Administrator has acquiesced and determined that, consistent with the Medicare statute, any such final determination must be in according [sic] with a revised matching process and include non-covered days in the SSI fraction."[8]

The Intermediary 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.[9]

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[6] U. S. v. Ruiz, 536 U.S. 622, 627-28 (2002) (Provider's Legal Authorities, Tab 8); U.S. v. United Mine Workers, 330 U.S. 258 (1947) (Provider's Legal Authorities, Tab 9) ; See also Tr. at. 20-29.
[7] Intermediary's August 27, 2010 Comments on Providers' Request for [EJR] at 7.
[8] Id.
[9] Id. at 8-9.

The Intermediary also argues that EJR cannot be granted until all factual disputes are resolved in the administrative process, and that the amount in controversy constitutes a factual dispute that cannot be quantified until a new payment determination is made.[10] The Providers respond that neither the EJR statutory provisions nor the regulations require disposition of factual disputes as a condition precedent to EJR[11] 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 the Intermediary relies to deprive the Board of jurisdiction is that the Ruling has effectively vacated the Intermediaries' payment determinations at issue here and the parties' 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" of the intermediary as to the amount of program reimbursement due a provider for a cost reporting period. 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.[12] 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 that dual eligible days and Medicare Part C days be counted in the Medicaid fraction, and forbids their inclusion in the SSI fraction. It is undisputable that the Ruling mandates that Part A exhausted and MSP days be counted in the SSI fraction,[13] despite acknowledging that the regulation in effect in the relevant time frame prohibited their inclusion.[14] Further, under the Ruling, it appears that Medicare Part C days would also be included in the SSI fraction, at least for periods on or after October 1, 2004.

The Intermediary asserts that through the Ruling it is acquiescing in the District Court's decision in Baystate and that the Providers' claims are now resolved and moot.

> The Administrator has acquiesced to certain relief and, without new Medicare payment determinations, the currently pending appeals are moot. Pursuant to the Ruling, CMS and its contractors will resolve each pending DSH appeal on the SSI issue where it is alleged that the matching process failed to use the "best available evidence" and in which the hospital seeks inclusion in the DPP of patient days where the patient was entitled to Part A benefits but the hospital stay was not covered under Part A or the patient's Part A hospital benefits were exhausted. For such properly pending appeals -- including these group appeals -- the hospital's SSI fractions (provided that the patient was also entitled to SSI) and

[10] Id. at 12-13.
[11] See 42 C.F.R. §405.1842(f)(2008).
[12] See 42 C.F.R. §405.1803(a)(2)
[13] Ruling at 8-14.
[14] Id. at 8.

> DSH payment adjustment will be recalculated for the period at issue by including the inpatient days of a person entitled to Medicare Part A in the numerator of the hospital's SSI fraction and in that fraction's denominator, even if the inpatient stay was not covered under Part A or the patient's Part A hospital benefits were exhausted.[15]

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, 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. It reasons that the providers may be satisfied with the outcome but, if not, *then* they can appeal.[16]

The Providers argue that adding Part A exhausted benefit days, MSP days and Part C days to the SSI fraction cannot rationally be said to render moot the Providers' pending claims to have the SSI fraction calculated correctly. The Providers argue 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."). The Providers also point out that the two courts that have ruled on the matter found CMS's position inconsistent with the statute, citing Northeast Hospital v. Sebelius, 699 F. Supp. 2d 81 (D.D.C. 2010) and Metropolitan Hospital v. Department of Health and Human Services, 702 F. Supp. 2d 808 (W.D. Mich. 2010). These decisions further indicate that the legal dispute is in fact a live controversy.[17]

The Board can find no factual justification in the record for CMS' argument that the Ruling vacated the NPRs at issue or the Ruling's premise that Providers' claims in their appeals from those NPRs are now moot. Nothing in the Ruling says that it has, in fact, vacated any NPR nor does that term appear anywhere in the Ruling. The Ruling is not self-executing. It does not identify and vacate any specific NPR nor does it purport to vacate any more general class of NPRs. By its terms, the Ruling first requires the Board to make a determination that an appeal from an NPR concerns one of the three issues the Ruling addresses, and a further determination that the appeal on one or more of those issues is jurisdictionally proper. Absent either of those two determinations, the Ruling does not have any effect at all on an NPR or an appeal from an NPR. And, even after the Board makes both those determinations with respect to a particular appeal from an NPR, the Ruling does not purport to vacate the NPR at that moment. The Ruling instead directs the Board to remand the appeal to the contractor for further processing. However, even at that point, the Ruling still does not purport to have the effect of vacating the NPR. If the contractor should determine, for example, that the appeal did not in fact concern

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[15] Intermediary's August 27, 2010 Comments on Providers' Request for [EJR] at 6.
[16] Ruling at 12-14.
[17] EJR Request at 3-4.

one of the three issues the Ruling addresses, then the contractor is directed under the Ruling to so notify the Board, which, at that point, is directed to resume the appeal.

The Board is also unable to find legal support for CMS' position that the Ruling vacates the NPRs at issue. The Medicare regulations establish two procedures for review and revision of a final determination of an intermediary in an NPR. One process is the "reopening" process pursuant to 42 C.F.R. § 405.1885. Under the reopening regulation, jurisdiction to reopen a determination lies with the entity that rendered the determination, in this case, the Intermediary. 42 U.S.C. § 405.1885(c). In some instances, CMS may direct an intermediary to reopen an NPR, Id. § 405.1885(c)(1), but the regulation expressly prohibits CMS from directing an intermediary to reopen an NPR due to a "change of legal interpretation or policy by CMS in a . . . ruling." Id. § 405.1885(c)(2). That is precisely the situation here. The Ruling acknowledges that Part A exhausted benefit days and MSP days were not included in the SSI fraction under CMS policy for periods before October 1, 2004. The Ruling seeks to implement a change in that policy. Thus the reopening regulation precludes CMS from directing an intermediary to reopen an NPR for a cost reporting period before October 1, 2004 due to CMS' change in interpretation of policy in the Ruling.

The second process for review and revision of an intermediary determination in an NPR is through the appeals process that begins with an appeal to the Board pursuant to 42 U.S.C. § 1395oo. But CMS' Ruling could not "vacate" the NPRs at issue in these appeals through that process because these appeals were not pending before the CMS Administrator when CMS issued the Ruling. The appeals were and are still pending before the Board. The statute, 42 U.S.C. § 1395oo, and the implementing regulations grant the Board the sole and exclusive power to issue a decision on an appeal pending before the Board. The Secretary, of course, has the power to review a decision by the Board, 42 U.S.C. § 1395oo(f), but that comes later, after the Board has decided the appeal before it. In summary, we find no statutory or regulatory authority to preempt the Board's decision in a pending appeal.

As to mootness, the Board finds no justification for CMS' argument that the Providers' appeals challenging the accuracy of the SSI fraction to be rendered moot because CMS has determined to include days in the SSI fraction that the Providers specifically argue should be excluded from the SSI fraction and included in the Medicaid fraction. The Intermediary argues that through the Ruling, the Agency has acquiesced in the Providers' claims, but the Providers do not seek what the Ruling requires, so it cannot be said that the Ruling is submitting to the Providers' claims. Indeed, the Providers contend that the proposed "acquiescence" is in contravention of the statute and regulation, which prohibits the inclusion of Part A exhausted, MSP and Medicare Part C days in the SSI fraction and compels the inclusion of the Medicaid-eligible portion of those days in the Medicaid fraction. In further support of the Providers' position that their appeal is not moot, the Providers have offered evidence, which the Intermediary has not rebutted, showing that the addition of Part A exhausted, MSP, and Medicare Part C days to the SSI fraction would significantly reduce DSH payments to hospitals.

Even though the Board does not have authority over the validity of the Ruling, the factual premise regarding mootness is the very foundation for the Intermediary's position that the Board lacks jurisdiction. Having found the factual basis on which the Intermediary relies to be faulty, the question nevertheless remains whether 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. The Board concludes that EJR is appropriate for a federal court to resolve that question in that the Board is denied the power to rule on it.

Amount in Controversy

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. The Intermediary 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.[18] The Intermediary argues that it is "only after a new determination is made is it possible to determine whether the actual case or controversy -- between including these days in the Medicaid fraction or SSI fraction -- results in *any* dissatisfaction on the part of the Providers, and whether the amount in controversy of that dissatisfaction rises to a level necessary to sustain Board jurisdiction."[19]

The Providers have furnished evidence showing that Part A exhausted benefit days and MSP days were excluded from the SSI fraction for all cost reporting periods beginning before October 1, 2004 and that Part C days were excluded from the SSI fraction for all federal fiscal years before 2007. The Providers also furnished evidence showing that Part A exhausted benefit days and MSP days were knowingly allowed to be counted in the numerator of the Medicaid fraction from 1986 through the latter part of 2003. For example, the Providers have offered sworn testimony in two declarations that the Office of the Inspector General specifically reviewed an Intermediary's determination to count these days in the numerator of the Medicaid fraction, and allowed it, as late as 2003.[20] None of the evidence was rebutted.

The Providers have also presented un-rebutted evidence showing the estimated impact of CMS' errors in calculating their SSI fractions. The Providers acknowledge that the reimbursement impact at issue in these appeals will change upon recalculation under the Ruling, but they assert that the positive impact of the correction of the errors and omissions found by the District Court in Baystate would be effectively masked by an offsetting penalty imposed by the Ruling.[21]

The Providers also complain that their opportunity to challenge any element of the SSI percentage calculation is severely impeded by CMS' moratorium on the release of its source data for patient days included in its calculation of the SSI fractions. However, the Providers' consultant testified at the hearing regarding several different analyses by his firm of data obtained from CMS before the moratorium, which demonstrated the negative impact of including Part A exhausted, MSP, and Medicare Part C days in the SSI fraction. This evidence has not been rebutted by CMS.

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[18] Intermediary's August 27, 2010 Comments on Request for [EJR] at 8-9.
[19] Id. at 8.
[20] Provider Exhibits 3 and 4.
[21] EJR Request at 10.

The Providers dispute the Intermediary's contention that "CMS has always treated managed care days as days of patients entitled to benefits under Part A."[22] At the hearing, the Providers' consultant presented testimony concerning several different analyses performed by his firm, showing that Medicare Part C days were not counted in the SSI fraction prior to 2007, except by mistake. The Intermediary did not rebut this evidence.

To determine whether, and the extent to which, Medicare Part C days were or were not included in the SSI fraction prior to 2007, the Providers' consultant analyzed approximately 1.3 million patient days for 56 hospitals (including some hospitals involved in these appeals) relating to patients who were discharged during Federal fiscal year 2005.[23] Of those 1.3 million patient days, hospital records showed that approximately 175,000 of them were for patients who were enrolled in a Medicare Advantage plan under Part C. The consultant analyzed the patient level detail ("routine use data") produced by CMS for those 56 hospitals and found that only 47 days out of the total 175,000 Medicare Part C days were included in the denominator of the SSI fraction. Thus, of the total 1.3 million patient days included in the routine use data for these 56 hospitals, only 0.003555 percent of those days were attributable to patients enrolled in a Medicare Advantage plan under Part C.[24] The consultant testified that the 47 days that were included in the routine use data were likely there because the agency's computer program mistakenly recognized these days as Part A days because they had been erroneously billed to Part A and later billed correctly to Part C.[25]

The Providers also submitted evidence and testimony - again un-rebutted - regarding another analysis by their consultant of CMS' routine use data for 139 cost reporting periods ending prior to October 1, 2004. That analysis similarly showed that only a minute portion of those hospitals' Medicare Part C days - one-third of 1% of the days - were included in the denominator of the SSI fraction for those 139 cost reporting periods.[26]

The Providers' consultant testified that an additional analysis was done on data for 160 hospitals for four different fiscal years (2004-2007), comparing the denominators of CMS's published SSI fractions to the numbers of Part A days and Part C days in the hospitals' records.[27] That analysis showed that the denominators of the SSI fractions published by CMS for those periods were consistently less than the sum of the Part A days and the Part C days reflected in the hospitals' records.[28] According to the consultant, this means that CMS either did not count Part C days in the SSI fraction, as the analysis discussed above suggests (which is highly probable), or that CMS consistently missed hundreds of thousands of Part A days in its calculation of the SSI

[22] Intermediary's August 27, 2010 Comments on Request for [EJR] at 5.
[23] Tr. at 58-68; Provider Exhibit 7.
[24] Tr. at 63-64; Provider Exhibit 7. When confined to teaching hospitals, which were required to submit no-pay bills for Medicare part C patients to their fiscal intermediaries in order to receive IME and GME payments for those patients, the results were no less striking. Twenty-seven of the 56 hospitals were teaching hospitals, and the consultant's analysis showed that only 35 out of 145,000 Medicare part C days were counted in the SSI fraction for these hospitals. Tr. at 65-67; Provider Exhibit 8.
[25] Tr. at 63-68.
[26] Tr. at 52-58; Provider Exhibit 5.
[27] Tr. at 68-86; Provider Exhibit 9. The consultant testified that he was not able to compare the actual data relied upon by CMS in calculating the SSI fractions for these hospitals because CMS had been unwilling to produce the data. Tr. at 125-26.
[28] Tr. at 72-81.

fractions for these hospitals (which is highly improbable).[29]

The Providers offered additional evidence concerning the impact of adding Part C days to the SSI fraction, and excluding the Medicaid-eligible portion of those days from the numerator of the Medicaid fraction. The Providers' evidence showed that the addition of those days to the SSI fraction would reduce DSH payments to hospitals by approximately $450,000 per hospital per year, or approximately $775 million per year if extrapolated to 1,700 of approximately 2,000 DSH hospitals nationwide.[30]

In addition, the Providers presented testimony and evidence showing that including Part A exhausted and MSP days in the SSI fraction, while excluding the Medicaid eligible portion of those days from the Medicaid fraction, would further significantly reduce providers' DSH payments. 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 routine use data for one year, 2005, that CMS had furnished for 52 hospitals, though not necessarily including the hospitals involved in this appeal.[31] The Providers advise they are limited to using this data to calculate the difference between the two approaches because CMS then imposed a moratorium on furnishing any further source data.

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.[32] 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.[33] In addition, the Providers' presented testimony that Medicaid-eligible Part A exhausted and MSP days were included in the Medicaid fraction for hospitals going back at least to the early 1990s.[34]

The Providers also point out that the Intermediary has not furnished any evidence to dispute their assertion that they will be harmed by counting Part A exhausted benefit days, MSP days and Medicare Part C days in the SSI fraction even though CMS has that evidence at its disposal for all the years at issue. Further, the Providers argue that hospitals have never been given access to the data that CMS alone possesses, and which the hospitals would need to identify the precise

[29] Tr. at 72-81.
[30] See M+C Hearing transcript at 162-80, Provider Exhibit 5.
[31] Pfeil Declaration, May 12, 2010, Provider Exhibit 3; Tr. at 114-17.
[32] Pfeil Declaration May 12, 2010, at ¶ 17, Provider Exhibit 3; Tr. at 114-17; see also Provider Exhibit 11.
[33] Pfiel Declaration, June 4, 2010, at ¶¶ 2-8, Provider Exhibit 3; see also Provider Exhibit 11.
[34] Tr. at 109-14; see also Provider Exhibit 12.

impact of the systemic errors and omissions that *Baystate* required CMS to correct.

As noted, there was no rebuttal offered of the Providers' evidence concerning the Agency's treatment of Part A exhausted benefit days, MSP days and Medicare Part C days in the DSH calculation despite multiple opportunities and despite CMS having sole possession and control of the data to which the Providers access is limited. From the Intermediary's failure to present any evidence opposing the Providers' evidence, the Providers state that the Board may draw the inference that the Intermediary's evidence would support the Providers' position and would show both that these days were not previously counted in the SSI fraction and that the addition of these days to the SSI fraction would reduce DSH payments to the Providers in these groups. In this regard, the Board notes that CMS has within its sole possession and control of all the evidence bearing on these issues.

The Board, therefore, finds the evidence sufficient to show that, if the Providers prevailed on their substantive claim, the recovery would likely substantially exceed the jurisdictional amount. However, because 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. The Board concludes that question is appropriate for EJR.

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 the Ruling as to the treatment of Part A exhausted, MSP, and Medicare Part C days in the SSI fraction. 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. The question of the Board's jurisdiction can then 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 in these circumstances where jurisdiction is in doubt, EJR to determine the validity of the Ruling as to jurisdiction is the only "orderly and proper proceeding"[35] available to it.

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.

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

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.

In a prior proceeding regarding the Ruling, 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]."[36] 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 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.

The Intermediary also urges the Board to consider the following principles behind administrative exhaustion[37] 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

[36] Transcript at 96 from Southwest Consulting 2004 DSH Dual Eligible Group et al. v. BlueCross Blue Shield Association/Wisconsin Physicians Service, PRRB Dec. No. 2010-D36 (Medicare & Medicaid Guide (CCH) at ¶ 82,644) (June 14, 2010).

[37] 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 August 27, 2010 Comments on Providers' Request for [EJR] at 12.

> (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."

The Intermediary 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.[38]

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 the Intermediary 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.[39]

In that the Intermediary has invited the Board to consider these general exhaustion principles, the Board finds other exhaustion principles 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 discovering and correcting errors. The battle over which component of DSH is appropriate for counting dual eligible days and Medicare Part C 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 that 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 be the prevailing view.

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[38] Intermediary's August 27, 2010 Comments on Providers Request for [EJR] at 12.
[39] EJR Request at 10.

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.[40] 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"[41] [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 the Intermediary 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.

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

(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.

[40] Providers' consultants assert they have over 500 requests pending or waiting to be filed when CMS lifts its moratorium. See Declaration of David Pfiel at ¶ 12.
[41] Ruling at 17.

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

Date: Sept. 24, 2010