DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Novitas Solutions. Inc.
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RE: ***Jurisdictional Determination***
Integris Seminole Medical Center (37-0229)
FYE March 31, 2013
Case No: 16-1428

Dear Messrs. Summar and Lattimore:

This case involves Integris Seminole Medical Center's ("Provider") appeal of its Medicare reimbursement for the fiscal year ending ("FYE") on March 31, 2013 ("FY 2013"). The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed Provider's documentation and finds that it does not have jurisdiction to hear Provider's appeal of Issue 1, Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") "provider-specific"; Issue 8, DSH/Part C Days; and Issue 9, DSH/Dual Eligible Days as set out within Provider's April 8, 2016 Request for Hearing ("RFH"), as these issues are duplicative of other issues that were transferred to group appeals. The Board, therefore, dismisses these issues from the instant appeal but the appeal remains open as Provider's Medicaid Eligible Days are still being challenged. The Board's findings and jurisdictional determinations are explained below.

PERTINENT FACTS

On April 8, 2016, the Board received Provider's October 22, 2015 RFH regarding its Notice of Program Reimbursement ("NPR") for FY 2013. In its RFH, Provider initially challenged nine issues then transferred five to group appeals leaving the instant appeal with the following four issues— Issue 1, DSH/SSI "provider-specific"[1]; Issue 7, Medicaid Eligible days; Issue 8, DSH—Part C Days; and Issue 9, DSH—Dual Eligible Days.

Issue 1—SSI Provider Specific

Within its RFH, Provider challenges its SSI percentage in its first two issues:

- Within Issue 1, "Provider contends that its[] SSI percentage . . . was incorrectly computed because [the Centers for Medicare & Medicaid Services ("CMS")] failed to include all patients that were entitled to SSI benefits in their calculation." Provider

[1] Provider's Issue 2, titled "DSH/SSI," also challenges its SSI percentage.

goes on to state that it "is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage." Provider also states that it "preserves its right to request . . . that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[2]

- For Issue 2, Provider challenges its SSI percentage based on (1) the availability of MEDPAR and SSA records, (2) paid days v. eligible days, (3) not in agreement with Provider's records, (4) fundamental problems in the SSI percentage calculation, (5) covered days v. total days, and (6) failure to adhere to required notice and comment rulemaking procedures.[3] Provider requested that the Board transfer Issue 2 to a group appeal, PRRB Case No. 16-0677GC, in correspondence dated November 12, 2016.

Issue 8—DSH-Part C Days

Within its RFH, Provider has 3 issues concerning its challenge to Part C Days. Issues 3 and 5 are "mirror-image" issues challenging CMS' treatment of Part C days within the Medicare and Medicaid fractions, respectively.[4] Each of these issues has been transferred to a group appeal with the same common issue.[5] In Issue 8, Provider sets out a "general" Part C Days issue that combines Issues 3 and 5 and claims that the "[Medicare Advantage] days should be excluded from their Medicare fractions, and included instead in the Medicaid fraction of their DSH calculation."[6]

Issue 9—DSH-Dual Eligible Days

Similar to the Part C Days issue above, Issues 4 and 6 are mirror-images of each other, one challenging CMS' treatment of dual eligible days in the Medicare fraction and one challenging the same in the Medicaid fraction.[7] Issue 9's issue statement, however, is *exactly* the same as Issue 6's issue statement.[8]

BOARD'S ANALYSIS AND DECISION

A. Applicable Regulatory Provisions and Board Rules

Pursuant to 42 C.F.R. §§ 405.1835-405.1840 (2015), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare Contractor, the amount in controversy is $10,000 or more, and the request for hearing is filed within 180 days of the date of receipt of the final determination.

[2] RFH TAB 3 at unnumbered page 1.
[3] *Id*. at unnumbered pages 1-2.
[4] *See* RFH TAB 3 at unnumbered pages 2-5.
[5] Provider made the transfer requests in correspondence dated November 12, 2016.
[6] RFH TAB 3 at unnumbered page 7.
[7] *See* RFH TAB 3 at unnumbered pages 3-6.
[8] *Id*. at unnumbered page 11.

Under 42 C.F.R. § 405.1835(a)(1) (2015), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either: (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Under Board Rule 4.6.1 (August 29, 2018),[9] a provider may not appeal an issue from a single final determination in more than one appeal.

B. Issue 1—SSI Provider-Specific

In its RFH, Provider summarizes its SSI Provider-Specific issue in the following manner:

> The Provider contends that its[]SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]. . . The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[10]

Provider describes its DSH/SSI issue, Issue 2, as quoted below:

> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[11]

In its SSI Systemic issue description, Provider sets out a long list of reasons why it claims that CMS incorrectly computed its SSI percentage. In its SSI Provider-Specific issue statement, Provider fails to describe any additional reasons or patient populations "entitled to SSI benefits"

[9] Formerly, Board Rule 4.5 (July 1, 2009).
[10] RFH TAB 3 at unnumbered page 1.
[11] *Id*. at unnumbered page 2.

that would distinguish the two issues or in any way differentiate the underlying data being challenged. The Board concludes, therefore, that Provider's SSI Provider-Specific issue and its DSH/SSI issue that was transferred to Case No. 16-0677GC, challenge the same underlying SSI data and are, ultimately, the same issue. The SSI Provider Specific issue is hereby dismissed from this appeal.

C. Issue 8—DSH Part C Days

As previously set out above, the Board finds that Provider's Issue 8 Issue Statement combines Provider's Issues 3 and 5, thus is duplicative of those two issues.

D. Issue 9—DSH Dual Eligible Days

As previously set out above, the Board finds that Provider's Issue 9 Issue Statement is a duplicate of Provider's Issue 6.

CONCLUSION

The Board finds that Provider's Issues 1, 8 and 9 are duplicative of other issues that have been transferred to group appeals. As Board Rule 4.6.1 does not permit a provider to have the same issue from a single determination in more than one appeal, the Board hereby dismisses these issues from the instant appeal. In addition, although Provider's SSI Provider-Specific issue statement contains a declaration that the "Provider . . . preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period[,]"[12] the Board reminds Provider that a provider's written request to realign its SSI percentage is a provider-election submitted to the Medicare Contractor and not an appealable issue before the Board.[13]

The only issue that remains pending in Case No. 16-1428 is the Medicaid Eligible Days issue. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:

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

For the Board:

10/2/2019

X Clayton J. Nix

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

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

[12] 42 C.F.R. § 412.106(b)(3) (2010).
[13] 42 C.F.R. § 405.1835(a) (2010).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
15-2551GC McLaren Healthcare 2013-2014 DSH Medicare/Medicaid Part C Days Group
16-2150G Hall Render 2014 DSH Medicare/Medicaid Part C Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' September 6 and 9, 2019 requests for expedited judicial review ("EJR") (both received September 10, 2019) for the appeals referenced above.[1] The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> The improper inclusion by the [Medicare Contractor] and the Centers for Medicare & Medicaid Services (CMS) of inpatient days attributable to Medicare Advantage patients in the numerator and [denominator] of the Medicare Proxy when calculating the disproportionate share hospital (DSH) eligibility and payments.[2]

Statutory and Regulatory Background: Medicare DSH Payment

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

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[1] The Board bifurcated the appeal for McLaren Port Huron (Provider No. 23-0216, FYE 6/30/2014) in Case No 15-2551GC so the Provider's partial cost reporting period from 7/1/2013-9/30/13 is contained in Case No. 15-2551GC. The remainder of McLaren Port Huron's cost reporting period (10/1/2013-6/30/2014) is contained in an individual appeal, Case No. 19-2680. The Board also bifurcated all of the participants appeals in Case No. 16-2150G which now contains the cost reporting periods on or before 9/30/2013 and the periods on or after 10/1/2013 have been assigned Case No. 19-2695G.
[2] Providers' EJR Request at 2.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[24] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* (*Allina II*),[26] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[27] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[28] Once again, the Secretary has not acquiesced to this decision.

Providers' Requests for EJR

The Providers assert that that the Medicare fraction of the DSH calculation is improperly understated due to the Secretary's erroneous inclusion of inpatient days attributable to Medicare Advantage patients in both the numerator and the denominator of the of the Medicare fraction. The failure to include such days in the Medicaid fraction also understated that fraction. The

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] 72 Fed. Reg. at 47411.
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.

Providers point out that the authority upon which CMS relied to collect Medicare Advantage days information is the DSH regulation at 42 C.F.R. § 412.106, which includes Medicare Advantage days in the description of the days included in the Medicare fraction. However, the enabling statute for this regulation, 42 U.S.C. § 1395ww(d)(5)(f), makes no mention of the inclusion of Medicaid Advantage days in the Medicare fraction, only traditional Part A days. The Providers contend that Medicare Advantage beneficiaries are not entitled to benefits under Part A, but instead are entitled to benefits under Part C. As a result, the Providers are challenging the validity of the regulation to the extent that 42 C.F.R. § 412.106 contradicts the enabling statute at 42 U.S.C. § 1395ww(d)(5)(f).[29]

In challenging the validity of the regulation, the Providers assert that the regulation was adopted in violation of the Administrative Procedures Act (APA). They contend that the Secretary violated the APA when she deprived the public the opportunity to comment on the regulation. This position was upheld in the decisions in both *Allina I* and *Allina II*.[30]

The Providers argue that any Medicare Advantage days that are also dual eligible days cannot be counted in the Medicare ratio for the same reasons as set forth above. Primarily, they believe, the regulation requiring inclusion of dual eligible days in the Medicare ratio is invalid and the days must be counted in numerator of the Medicaid fraction. This allegedly improper treatment resulted in the under payment to Providers as DSH eligible providers of services to indigent patients, and includes any other related adverse impact to DHS payments, such as capital DSH payments.[31]

With respect to EJR, the Providers believe that the Board has jurisdiction over the matter at issue and lacks the legal authority to decide the legal question presented. The Providers posit that the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the APA and the statute and is bound by Secretary's actions. The Providers do not believe that the Board has the authority to implement the effect of *Allina I.*

Decision of the Board

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

[29] *Id.* at 2.
[30] *Id.*
[31] *Id.*

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving FY 2013 or portions thereof prior to 10/1/2013.[32]

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[33] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[34]

On August 21, 2008, new regulations governing the Board were effective.[35] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[36] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[37]

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

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[32] *See supra* note 1.
[33] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[34] *Bethesda*, 108 S. Ct. at 1258-59.
[35] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[36] 201 F. Supp. 3d 131 (D.D.C. 2016)
[37] *Id.* at 142.

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. The participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[38] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction over the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2013 cost reporting period or portions thereof prior to October 1, 2013.[39] Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[40] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[41] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.[42]

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year[43] and that the participants in these group appeals are entitled to a hearing before the Board;

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

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

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[38] *See* 42 C.F.R. § 405.1837.
[39] *See supra* note 1.
[40] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[41] *See* 42 U.S.C. § 1395oo(f)(1).
[42] Wisconsin Physicians Service ("WPS"), filed objections to the EJR requests. In its filings, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.
[43] *See supra* note 1.

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

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
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Robert A. Everts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

10/4/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Corinna Goron
Healthcare Reimbursement Services, Inc.
17101 Preston Rd., Ste. 220
Dallas, TX 75248

RE: ***EJR Determination***
15-2186GC HRS UHHS 2011 DSH SSI Fraction Medicare Managed Care Part C Days Grp
15-2187GC HRS UHHS 2011 DSH Medicaid Fraction Medicare Mngd Care Part C Days Grp

Dear Ms. Goron:

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

Issue in Dispute:

The issue in these appeals is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

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

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

> *part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[11]

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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

[17] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[18] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[19] 69 Fed. Reg. at 49099.

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

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

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

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

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

fraction had been vacated in *Allina I*.[27] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[28] Once again, the Secretary has not acquiesced to this decision. The Supreme Court issued a decision in *Azar v. Allina Health Services*[29] in which the Court considered whether the government had violated the 60-day notice requirement of 42 U.S.C. § 1395hh(a)(2) when it posted the 2012 Medicare fractions on its website. Affirming the court of appeals finding, the Court concluded that §1395hh(a)(2) the government's action changed a substantive legal standard and, thus required notice and comment.

Providers' Request for EJR

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

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

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2011.

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[27] *Id.* at 943.
[28] *Id.* at 943-945.
[29] No. 17-1484, 2019 WL 2331304 (June 3, 2019).
[30] Providers' EJR Request at 1.

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

On August 21, 2008, new regulations governing the Board were effective.[33] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required, for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[34] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[35]

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

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

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[36] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying, remaining providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the 2011 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[37] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[38] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

10/9/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Judith Cummings, CGS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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Indianapolis, IN 46204

RE: ***Expedited Judicial Review Determination***
16-2225GC Community Health Network 2013 DSH Medicare/Medicaid Part C Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' September 16, 2019 request for expedited judicial review ("EJR") (received September 17, 2019) for the appeal referenced above.[1] The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in this appeal is:

> The improper inclusion by the [Medicare Contractor] and the Centers for Medicare & Medicaid Services (CMS) of inpatient days attributable to Medicare Advantage patients in the numerator and [denominator] of the Medicare Proxy when calculating the disproportionate share hospital (DSH) eligibility and payments.[2]

Statutory and Regulatory Background: Medicare DSH Payment

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

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] These cases involve the hospital-specific DSH adjustment, which requires the

[1] The Board bifurcated the appeals for four participants in Case No. 16-2225GC so the Providers' partial cost reporting periods from 10/1/2013-12/31/13 is contained in Case No. 19-2697GC. Those portions of the four Providers fiscal periods prior to 10/1/2013 will remain in Case No. 16-2225GC.
[2] Providers' EJR Request at 2.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).

Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.
[15] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[16] *Id.*
[17] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [18]

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

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

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

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . .* if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[21]

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contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

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

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

[20] 69 Fed. Reg. at 49099.

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[24] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* (*Allina II*),[26] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[27] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[28] Once again, the Secretary has not acquiesced to this decision.

Providers' Requests for EJR

The Providers assert that that the Medicare fraction of the DSH calculation is improperly understated due to the Secretary's erroneous inclusion of inpatient days attributable to Medicare Advantage patients in both the numerator and the denominator of the of the Medicare fraction. The failure to include such days in the Medicaid fraction also understated that fraction. The Providers point out that the authority upon which CMS relied to collect Medicare Advantage days information is the DSH regulation at 42 C.F.R. § 412.106, which includes Medicare Advantage days in the description of the days included in the Medicare fraction. However, the enabling statute for this regulation, 42 U.S.C. § 1395ww(d)(5)(f), makes no mention of the inclusion of Medicaid Advantage days in the Medicare fraction, only traditional Part A days. The Providers contend that Medicare Advantage beneficiaries are not entitled to benefits under Part A, but instead are entitled to benefits under Part C. As a result, the Providers are

[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] 72 Fed. Reg. at 47411.
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.

challenging the validity of the regulation to the extent that 42 C.F.R. § 412.106 contradicts the enabling statute at 42 U.S.C. § 1395ww(d)(5)(f).[29]

In challenging the validity of the regulation, the Providers assert that the regulation was adopted in violation of the Administrative Procedures Act ("APA"). They contend that the Secretary violated the APA when she deprived the public the opportunity to comment on the regulation. This position was upheld in the decisions in both *Allina I* and *Allina II.*[30]

The Providers argue that any Medicare Advantage days that are also dual eligible days cannot be counted in the Medicare ratio for the same reasons as set forth above. Primarily, they assert that the regulation requiring inclusion of dual eligible days in the Medicare ratio is invalid and that the days must be counted in numerator of the Medicaid fraction. This allegedly improper treatment resulted in the under payment to Providers as DSH eligible providers of services to indigent patients, and includes any other related adverse impact to DHS payments, such as capital DSH payments.[31]

With respect to EJR, the Providers assert that the Board has jurisdiction over the matter at issue and lacks the legal authority to decide the legal question presented. The Providers posit that the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the APA and the statute and is bound by Secretary's actions. The Providers do not believe that the Board has the authority to implement the effect of *Allina I.*

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2013 but only that portion of the fiscal year prior to October 1, 2013.[32]

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

[29] *Id.* at 2.
[30] *Id.*
[31] *Id.*
[32] *See supra* note 1.

Bowen ("*Bethesda*").[33] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[34]

On August 21, 2008, new regulations governing the Board were effective.[35] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[36] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[37]

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

A. Jurisdiction Determination on #1 Community Howard Regional Health System (Provider No. 15-0007, FYE 1/1/2013-9/30/2013)

At the outset, the Board notes that a Board finding of jurisdiction is a prerequisite to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority request "[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision,"[38] including documentation relating to jurisdiction.

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[33] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[34] *Bethesda*, 108 S. Ct. at 1258-59.
[35] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[36] 201 F. Supp. 3d 131 (D.D.C. 2016).
[37] *Id.* at 142.
[38] 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which included a decision on both jurisdiction and the EJR request).

Similarly, the regulations governing group appeals specify that jurisdiction "may be raised at any time."[39]

Participant #1 Community Howard Regional Health System (Provider No. 15-0007) appealed its revised NPR that did not adjust the Part C issue as required for Board jurisdiction. Rather, the audit adjustment that is the subject of this appeal was an adjustment that implemented the SSI realignment.

The regulation, 42 C.F.R. § 412.106(b)(3), permits a provider to request to have its data reported on its cost reporting period instead of the Federal fiscal year. To do so, "It must furnish to CMS, through its Intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period."

Community Howard Regional Health System requested that its SSI percentage be recalculated from the federal fiscal year to its cost reporting year. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data and process remains the same, it is simply that a different time period is used.[40] Indeed, the regulation at issue and its application does not change with realignment. The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the September 30 FFY.[41]

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

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

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[39] 42 C.F.R. 405.1837(e)(2) states: "*The Board may make jurisdictional findings* under § 405.1840 ***at any time***, including, but not limited to, following a request by the providers for the jurisdictional findings. The providers may request jurisdictional findings by notifying the Board in writing that the group appeal is fully formed, or that the providers believe they have satisfied all of the requirements for a group appeal hearing request, and the Board may proceed to make jurisdictional findings."

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

[41] As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis.

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

Since the revised NPR for Community Howard Regional Health System did not adjust the Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that is lacks jurisdiction over the revised NPR and hereby dismisses the appeal of the revised NPR for the Provider. Because jurisdiction over a provider is a requisite to granting a request for EJR, the Board hereby denies the Provider's request for EJR as it relates to the revised NPR.

B. Jurisdiction over the Remaining Providers

The Board has determined that the remaining participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. The remaining participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[42] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction over the above-captioned appeals and the underlying remaining participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2013 cost reporting period but only that portion of the cost reporting period prior to October 1, 2013.[43] Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[44] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[45] Based on the

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

above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.[46]

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year[47] and that the remaining participants in this group appeal are entitled to a hearing before the Board;

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

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

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

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

Board Members Participating:

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

For the Board:

10/9/2019

X Clayton J. Nix

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

Enclosure: Schedule of Providers

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

[47] *See supra* note 1.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Saint Vincent Hospital
232 West 25th Street
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Bruce Snyder
Director, JL Provider Audit & Reimbursement
Novitas Solutions. Inc.
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: Jurisdictional Determination
Saint Vincent Hospital (Provider No. 39-0009)
FYEs: June 30, 2012, June 30, 2013
Case Nos.: 16-1794, 16-1796

Dear Mr. Wisniewski and Mr. Snyder:

This case involves Saint Vincent Hospital's ("Provider") appeal of its Medicare reimbursement for the fiscal years ending ("FYE") on June 30, 2012, and June 30, 2013. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed Provider's documentation in response to the Medicare Contractor's Jurisdictional Challenges and finds that it does not have jurisdiction to hear Provider's appeal of the Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") "provider-specific" issue in either appeal. Accordingly, as set forth below, the Board dismisses these issues from their respective appeals.

PERTINENT FACTS

On May 25, 2015, the Board received Provider's timely filed individual appeal requests ("RFH") for its FYE June 30, 2012, and June 30, 2013, NPRs. In both appeals, Provider initially appealed six issues, but after requesting transfers and withdrawals, the appeals are left with two issues each:

Issue 1 – DSH/SSI provider-specific with realignment request; and
Issue 3 – Medicaid Eligible Days.

In September 2019, the Medicare Contractor filed Jurisdictional Challenges regarding Provider's Issue 1 in both appeals.[1] In its Jurisdictional Challenges, the Contractor claims that, in each of these appeals, Provider's Issue 1 is its Issue 2 and that Issue 1 contains a premature request for SSI realignment.

[1] For Case No. 16-1794, the Medicare Contractor filed its Jurisdictional Challenge on September 25, 2019 and, for Case No. 16-1796, the Contractor filed its Jurisdictional Challenge on September 23, 2019.

The RFHs in these appeals are virtually identical for Issues 1 and 2. Within the RFHs, the Provider challenges its SSI percentage in its first two issues as shown by the following excerpts from the Provider's appeal in both cases:

Issue 1 "Provider contends that its[] SSI percentage . . . was incorrectly computed because [the Centers for Medicare & Medicaid Services ("CMS")] failed to include all patients that were entitled to SSI benefits in their calculation." Provider goes on to state that it "is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage." Provider also states that it "preserves its right to request . . . that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[2]

Issue 2 Provider challenges its SSI percentage based on (1) the availability of MEDPAR and SSA[3] records, (2) paid days v. eligible days, (3) not in agreement with Provider's records, (4) fundamental problems in the SSI percentage calculation, (5) covered days v. total days, (6) non-covered days, (7) CMS 1498-R, and (8) failure to adhere to required notice and comment rulemaking procedures.[4]

In correspondence dated January 26, 2017, Provider requested that the Board transfer Issue 2 from Case No. 16-1794 to the group appeal under Case No. 16-1756G and Issue 2 from Case No. 16-1796 to the group appeal under Case No. 16-1141G.

BOARD'S ANALYSIS AND DECISION

A. Applicable Regulatory Provisions and Board Rules

Pursuant to 42 C.F.R. §§ 405.1835-405.1840 (2015), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare Contractor, the amount in controversy is $10,000 or more, and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2011), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either: (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

[2] RFH at Tab 3, unnumbered page 1 (for both appeals).
[3] The term "MEDPAR" stands for the "Medicare Provider Analysis and Review database." The term "SSA" stands for "Social Security Administration."
[4] RFH at Tab 3, unnumbered pages 1-9 (for both appeals).

Under Board Rule 4.6.1 (August 29, 2018),[5] a provider may not appeal an issue from a single final determination in more than one appeal.

B. Issue 1—SSI "Provider-Specific"

In its Issue 1 Issue Statements, Provider claims that "CMS failed to include all patients that were entitled to SSI benefits in their calculation[,]" whereas in its Issue 2 Issue Statements, Provider sets out a more detailed list of reasons why it claims that certain patients were not included in its SSI percentage. However, the Provider fails to describe additional reasons or patient populations "entitled to SSI benefits" that would distinguish the issues or in any way differentiate the underlying data being challenged. The Board concludes, therefore, that Provider's Issue 1 and its Issue 2 challenge the same underlying SSI data and are, ultimately, the same issue, in both appeals.

C. DECISION

Provider impermissibly has the same issue from a single final determination in two separate appeals,[6] thus the Board hereby dismisses Provider's Issue 1 from both Case No. 16-1794 and Case No. 16-1796. As Provider previously transferred its Issue 2 from both appeals to the appropriate group appeals, Provider's challenge to its underlying SSI data remains open within those cases. In addition, the Board reminds the Provider that a provider's *request* to realign its SSI percentage with the hospital's own cost reporting period is a provider *election*,[7] not an appealable issue before the Board.[8]

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

Board Members Participating:

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For the Board:

10/11/2019

X Clayton J. Nix

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Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, FSS

[5] Formerly, Board Rule 4.5 (July 1, 2009).
[6] *See* Board Rule 4.6.1 (August 29, 2018).
[7] 42 C.F.R. § 412.106(b)(3).
[8] Once realigned, the hospital's SSI percentage *may* be appealable from the revised final determination that reports the new calculation pursuant to the appeal rights delineated in 42 C.F.R. § 405.1889.//

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Memorial Hospital of York (Provider No. 39-0101)
FYE 06/30/2011
Case No. 16-2253

Dear Mr. Summar and Mr. Snyder,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the jurisdictional briefs and documents in Case No. 16-2253. The Board's findings and jurisdictional decision are explained below.

Pertinent Facts:

Memorial Hospital of York (the "Provider") appealed an original Notice of Program Reimbursement ("NPR") dated February 26, 2016 for its fiscal year end ("FYE") June 30, 2011 cost reporting period. On August 19, 2016, the Provider filed an individual appeal request which contained the following two issues:

1) Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific) ("DSH/SSI Percentage (Provider Specific)"), and

2) Disproportionate Share Hospital Payment - Medicaid Eligible Days ("DSH Medicaid Eligible Days").

The Medicare Contractor filed a Jurisdictional Challenge on May 1, 2018 regarding Issue No. 2 addressing DSH Medicaid Eligible Days and another one on August 20, 2019 regarding Issue No. 1 addressing DSH SSI Percentage (Provider Specific).

The Provider also appealed the same NPR and FYE in "Community Health Systems 2011 Post 1498-R DSH SSI Data Match CIRP Group" which is assigned Case No. 14-0288GC.

Medicare Contractor's Position

The Medicare Contractor challenges the Board's jurisdiction over Issue No. 2 addressing DSH Medicaid Eligible Days, stating it has made no final determination regarding this issue and the Provider has not properly preserved its right to claim dissatisfaction for the Medicaid ratio issues as self-disallowed items. The Medicare Contractor contends that the adjustments cited by the Provider do not render a final determination regarding the Medicaid ratio issue, and the Provider has failed to show the days sought were claimed on the cost report and then disallowed by the Medicare Contractor. The Medicare Contractor cites to 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835 in support of its position.

Additionally, the Medicare Contractor states the Provider did not protest this item. The Medicare Contractor concludes the Provider does not have a right to appeal the DSH Medicaid Eligible Days issue because the Provider has not preserved its right to claim dissatisfaction pursuant to 42 C.F.R. § 405.1835.

Regarding Issue No. 1 addressing DSH SSI Percentage (Provider Specific), the Medicare Contractor states this issue is actually three sub-issues: 1) SSI data accuracy; 2) realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The Medicare Contractor requests that Board dismiss the SSI realignment issue because the Medicare Contractor made no final determination regarding this issue. The Medicare Contractor also states that appeal of the SSI realignment issue is premature as the Provider has not exhausted all available remedies.

Provider's Position

The Provider filed a Jurisdictional Response on Sept. 17, 2019. The response asserts that the DSH/SSI Percentage issues in this appeal are separate and distinct and that the Board should find jurisdiction over both the SSI Systemic and SSI Provider Specific/Realignment issues. The Provider explains that the SSI Systemic issue addresses the various errors discussed in *Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008)* and that the SSI Provider Specific/Realignment issue addresses various errors of omission and commission that do not fit into the "systemic errors" category.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is

$10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Issue No. 1 – DSH/SSI Percentage (Provider Specific)

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

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

The Board finds that the first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Data Match Issue that this same Provider and fiscal year end directly added to PRRB Case No. 14-0288GC on August 23, 2016.

The DSH/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[1] The Provider's legal basis for its DSH/SSI (Provider Specific) issue also asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[2] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . specifically disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[3]

The Provider's DSH SSI Data Match issue in group Case No. 14-0288GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106. Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Data Match issue in group Case No. 14-0288GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5 (2015), the Board dismisses this aspect of the DSH/SSI Percentage (Provider Specific) issue.

[1] *Model Form A – Individual Appeal Request* (Aug. 18, 2016) at Tab 3, Issue 1.
[2] *Id.*
[3] *Id.*

The second aspect of the SSI Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment and, accordingly, the Board finds that, pursuant to 42 C.F.R. § 405.1835(a), the Provider has no determination upon which it can base an appeal of the realignment sub-issue.

Issue No. 2 - DSH Medicaid Eligible Days

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

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

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

In 2016, the D.C. federal district court held in *Banner Heart Hosp. v. Burwell* ("*Banner*")[4] that a provider cannot be held to the claim preservation/presentment requirement of 42 C.F.R. § 405.1835(a)(1) when the provider is challenging a Medicare regulation or policy which the Medicare contractor has no authority to entertain or decide (such as a challenge to a Medicare regulation or policy). The *Banner* court explained its decision as follows:

> …when a provider fails to present a claim in its cost report that [a Medicare contractor] can address, it can be deemed "satisfied" with the

[4] 201 F. Supp. 3d 131 (D.D.C. 2016).

> amounts requested in the cost report and awarded by the [Medicare contractor]. But where the [Medicare contractor] has no authority to address a claim, such as when a pure legal challenge to a regulation is at issue, a provider cannot be deemed to be "satisfied" simply because such challenge is not reflected in the cost report. Satisfaction cannot be imputed from a provider's silence when everyone knows that it would be futile to present such claim to the [Medicare contractor].[5]

The *Banner* court looked to the Supreme Court's 1988 decision in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*")[6] which addressed a similar challenge to a regulation which was not first presented to the Medicare contractor. *Bethesda* holds that a provider need not protest self-disallowed costs that are barred from being claimed because of a specific statute, regulation, or ruling.[7] The Supreme Court in *Bethesda* stated:

> . . . [T]he submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the [Contractor]. Providers know that, under the statutory scheme, the [Contractor] is confined to the mere application of the Secretary's regulations, that the [Contractor] is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the [Contractor] to do otherwise would be futile.[8]

In response to the *Banner* decision, CMS issued Ruling CMS-1727-R ("Ruling 1727") to set forth its policy to create an exception to the application of the claim preservation/presentment requirement of 42 C.F.R. § 405.1835(a)(1) consistent with (but broader than) the holding in *Banner*. In this regard, Ruling 1727 sets out a five-step analysis for the Board to undertake to determine whether a provider is entitled to a Board hearing for an item that the provider appealed but did not include on its cost report. In short, a provider has a right to a Board hearing for such an item if it excluded the item based upon "a good faith belief that the item was subject to a payment regulation or other policy that gave the Medicare contractor no authority or discretion to make payment in the manner the provider sought."[9]

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[5] *Id.* at 141.
[6] 485 U.S. 399 (1988).
[7] *Id.* at 404.
[8] *Id.*
[9] Ruling 1727 at unnumbered page 2.

The first step of analysis under Ruling 1727 involves the appeal's filing date and cost reporting period. The appeal must have been pending or filed after the Ruling was issued on April 23, 2018. In the instant case, the Board received the Provider's request for hearing on November 21, 2013, and the appeal was open on April 23, 2018. Thus, it satisfies the appeal pending date requirement. Additionally, the Ruling applies to appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016. This appeal involves a fiscal year end June 30, 2009 cost report. Thus, the appealed cost reporting period falls within the required time frame.

Second, the Board must determine whether the appealed item "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider."[10]

Under §§ 1815(a) and 1833(e) of the Social Security Act, no Medicare payments are made to a provider unless the provider has furnished information requested by the Secretary so that the Secretary may determine the amount of payment due. With respect to a hospital's Medicare DSH payment—comprised of the Medicare and Medicaid DSH fractions—part of the Secretary's regulations mandate that a DSH-eligible hospital "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed…and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day."[11]

In the instant appeal, the Provider states the number of Medicaid days reflected on its cost report does not reflect an accurate number, and it will be providing a listing of Medicaid days it believes to be accurate to the Medicare Contractor under separate cover.[12] Because these "missing" Medicaid eligible days were not included in the Medicaid fraction, the Provider claims that the Medicare Contractor's Medicaid DSH fraction calculation is incorrect.[13] In particular, the Provider asserts in its appeal request that the Medicare Contactor failed to include "Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date" (*i.e.*, after the date on which the cost report was filed).

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

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[10] Ruling 1727 at 6.
[11] 42 C.F.R. § 412.106(b)(4)(iii) (2010).
[12] Provider's Final Position Paper (July 30, 2019) at 8.
[13] *See Model Form A – Individual Appeal Request* (Aug. 18, 2016) at Tab 3, Issue 1.

The third, fourth and fifth steps of analysis under Ruling 1727 involve the Board's assessment of whether a provider's appeal has met the jurisdictional requirements set out in the applicable regulation.[14] As the Provider's appeal was timely filed and the estimated amount in controversy is over $10,000, the first two Board jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, Ruling 1727 sets out three different scenarios—in steps three, four and five—for the Board to consider.

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

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

Under step five of Ruling 1727, the Board is directed to consider the circumstances surrounding a provider's self-disallowance claim. In the instant appeal, however, the Provider did not self-disallow the DSH Medicaid Eligible Days issue, thus this step is not applicable to this appeal.

The Board finds that Memorial Hospital of York's DSH Medicaid Eligible Days issue is within the Board's jurisdiction, based upon the *Banner* rationale and Ruling 1727-R, as it would have been futile to present DSH Medicaid Eligible Days to the Medicare Contractor without proof of eligibility and State verification.[15] However, the Board also finds that only those DSH Medicaid Eligible Days which were not able to be verified prior to the cost report filing date are subject to the Board's jurisdiction under *Banner* and Ruling 1727-R, and that the Provider and the Medicare Contractor shall, based on information privy to these two parties, ascertain the DSH Medicaid Eligible Days that are subject to the Board's jurisdiction. It is the Board's understanding that the Provider has not yet submitted a listing of the days that it is contesting in this appeal to the MAC as explained in the Provider's Final Position

[14] 42 C.F.R. § 405.1835(a) (2010).
[15] For a thorough discussion of how the regulations bind and otherwise constrict providers and Medicare contractors in the reporting of Medicaid eligible days, *see* the Board's decision in *Barberton Citizens Hosp. v. CGS Adm'rs, LLC*, PRRB Dec. No. 2015-D5 (Mar. 19, 2015), *declined review*, CMS Adm'r (Apr. 22, 2015).

Paper (July 30, 2019) at page 8. The Provider should submit this listing immediately to the Medicare Contractor.

The appeal remains open for resolution of the DSH Medicaid Eligible Days issue. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members

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

FOR THE BOARD

10/15/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: *Jurisdictional Decision*
Lee Regional Medical Center (49-0012)
FYE 06/30/2012
Case No. 15-2500

Dear Mr. Ravindran and Ms. Huggins,

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

Background

The Provider submitted a request for hearing on April 29, 2015, based on a Notice of Program Reimbursement ("NPR") dated October 31, 2014. The hearing request included nine issues. The Provider transferred or withdrew a number of issues. The DSH SSI (Provider Specific) is the only issue remaining in the subject appeal.[1] The Medicare Contractor submitted its jurisdictional challenge on October 3, 2019 noting a jurisdictional impediment for issue 1.[2]

Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> …the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i).
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 42.106(b)(2)(i) of the Secretary's Regulations.
> The Provider contends that its' (sic) SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed

[1] See Provider's Final Position Paper cover page withdrawing the Medicaid Eligible day issue and stating that the SSI Provider Specific is the only remaining issue.
[2] Medicare Contractor's jurisdictional challenge at 3.

> because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[3]

Medicare Contractor's Position

The Medicare Contractor asserts that the components of Issue 1 regarding SSI data accuracy and individuals eligible for SSI but did not receive payments, are dulicates of Issue 2. Issue 2 was transferred to group case No. 16-0246GC. Provider has addressed the same issue in more than one appeal. The Medicare Contractor argues that the DSH SSI% - Provider Specific and the DSH SSI%- Systemic issues are considered the same issue.

The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.

The Medicare Contractor contends that the Provider's appeal of the SSI Realignment issue is premature as it did not make a determination with respect to the SSI Realignment issue. The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions. [4]

Board Decision:

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

Although presented as one issue, the Provider's SSI (Provider Specific) issue statement includes several distinct subparts. The first part of the issue statement reads:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's

[3] Medicare Contractor's jurisdictional challenge at Exhibit C-4.
[4] Medicare Contractor's jurisdictional challenge at 6-7.

> calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

The Board finds that this portion of the issue is duplicative of the issue in the QRS Wellmont HS 2012 DSH SSI Percentage (Systemic Errors) CIRP Group, case no. 16-0247GC[5], to which the Provider transferred issue 2. The issue statement for this group appeal reads, in part:

> The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statue 42 USC 1395ww(d)(5)(F)(i). …

Pursuant to PRRB Rule 4.6.1, "A provider may not appeal an issue from a single final determination in more than one appeal" therefore the Board finds that this part of the SSI Provider Specific issue statement is duplicative of the SSI Systemic Errors group issue, and dismisses the issue from the subject appeal.

Next, the Provider asserted that it "preserves the right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[6] Under 42 C.F.R. § 412.106(b)(3), "if a hospital prefers that CMS use its cost reporting data instead of the Federal Fiscal Year, it must furnish to CMS, through its intermediary, a written request . . ." Without a written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for purposes of appeal. Additionally, even if the Provider has requested (and received) a realignment of its SSI percentage, that is not a final determination from which the Provider can appeal, or with which the Provider can be dissatisfied, as required by 42 C.F.R. § 405.1835(a).

In conclusion, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue for the reasons discussed above. The Board hereby, closes Case No. 15-2500 as there are no remaining issues in the subject appeal.

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

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[5] NOTE: The Medicare Contractor refers to group case no. 16-0246GC. However, the SSI Systemic Errors issue was transferred to Group Case No. 16-0247GC. See Medicare Contractor's jurisdictional challenge at Exhibit C-1 page 3 of 6.

[6] Individual Appeal Request, Issue 1. (April 28, 2015)

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For the Board:

10/15/2019

X Gregory H. Ziegler

Gregory H. Ziegler, C.P.A, CPC-A
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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***

18-0698GC Trinity Health ATRA 2018 0.7% Reduction Group
18-0699GC BMHCC ATRA 2018 0.7% Reduction Group
18-1020G Michigan 2018 ATRA 0.7% Reduction Group

Dear Mr. Marcus:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' September 18, 2019 request for expedited judicial review ("EJR") for the FYs 2018-2019 MS-DRG Documentation and Coding Adjustment issue.[1] The above-captioned groups appealed from the final rule addressing the inpatient prospective payment system for federal fiscal year 2018 that was published on August 14, 2017 ("FY 2018 IPPS Final Rule").[2] The Board decision determining that EJR for FY 2018 is appropriate for the issue and federal fiscal year under appeal is set forth below.

Issue in Dispute

The issue before the Board for the FY 2018 IPPS Final Rule is:

> Whether the action of the [Secretary of the Department of Health and Human Services] imposing a 0.7% reduction . . . in the Medicare Inpatient Prospective Payment System ("IPPS") standardized amount is consistent with applicable law.[3]

[1] This EJR decision ***only*** addresses FY 201**8**. The Board is concurrently issuing an EJR decision for the three FY 2019 group appeals under separate cover as these FY 2019 groups are appealing a different CMS determination covering FY 2019.
[2] 82 Fed. Reg. 37990 (Aug. 14, 2017).
[3] EJR request at 1.

Statutory and Regulatory Background

In the federal year ("FY") 2008 inpatient prospective payment system ("IPPS") final rule,[4] the Secretary[5] adopted the Medicare severity diagnosis-related group ("MS–DRG") patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The Secretary maintains that, by increasing the number of MS–DRGs and more fully taking into account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs would encourage hospitals to improve their documentation and coding of patient diagnoses.[6]

In the FY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs could potentially cause an increase in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FY 2008, -1.8 percent for FY 2009, and -1.8 percent for FY 2010.[7]

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 ("TMA").[8] TMA § 7(a) reduced the documentation and coding adjustment made as a result of the MS–DRG system that the Secretary adopted in the FY 2008 IPPS final rule to -0.6 percent for FY 2008 and -0.9 percent for FY 2009.[9]

The Secretary implemented a series of adjustments required under TMA §§ 7(b)(1)(A) and 7(b)(1)(B) based on a retrospective review of FY 2008 and FY 2009 claims data. The Secretary completed these adjustments in FY 2013. However, the Secretary commented in the FY 2013 IPPS final rule that delaying full implementation of the adjustment required under TMA § 7(b)(1)(A) until FY 2013 had resulted in payments in FY 2010 through FY 2012 being overstated, and that these resulting overpayments could not be recovered.[10]

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[4] 72 Fed. Reg. 47130, 47140 through 47189 (Aug. 22, 2007).
[5] of the Department of Health and Human Services.
[6] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).
[7] *See* 82 Fed. Reg. 37990, 38008 (Aug. 14, 2017).
[8] Pub. L. 110–90, 121 Stat. 984 (2007).
[9] *Id.* at 986.
[10] *See* 82 Fed. Reg. at 38008.

Congress revisited TMA § 7(b)(1)(B) as part of the American Taxpayer Relief Act of 2012 ("ATRA").[11] Specifically, ATRA § 631 amended TMA § 7(b)(1)(B) to add clause (ii) which required the Secretary to make a recoupment adjustment or adjustments totaling $11 billion for discharges occurring during FYs 2014 to 2017. Per the revisions made by ATRA § 631(b), this adjustment "represents the amount of the increase in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied" (*i.e.*, represents the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under TMA § 7(b)(1)(A) until FY 2013).[12] As discussed above, this delay in implementing TMA § 7(b)(1) resulted in overstated payment rates in FYs 2010, 2011, and 2012 and the resulting overpayments could not have been recovered under the original TMA § 7(b).

The adjustment required under ATRA § 631 was a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, the Secretary "anticipated that any adjustment made to reduce payment rates in one year would eventually be offset by a positive adjustment in FY 2018, once the necessary amount of overpayment was recovered."[13]

However, Congress again stepped in to revise TMA § 7(b)(1)(B). First, in § 414 of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Congress revised TMA § 7(b)(1)(B) to add clause (iii) which replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023.[14] Second, in § 15005 of the 21st Century Cures Act ("21-CCA"),[15] Congress amended the MACRA revision in TMA § 7(b)(1)(B)(iii) by reducing the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points.[16]

The Secretary's actuaries "estimated that a -9.3 percentage point adjustment to the standardized amount would be necessary if CMS were to fully recover the $11 billion recoupment required by [ATRA § 631] in FY 2014." Consistent with the policies that the Secretary has adopted in many similar situations, the Secretary implemented a phased in approach. For the first year, FY 2014, he implemented a -0.8 percentage point recoupment adjustment to the standardized amount. The Secretary declined, at that time, to set specific adjustments for FYs 2015, 2016, or 2017 "[a]s estimates of any future adjustments are subject to variations in total savings."[17] However, he did "estimate[]" that, if adjustments of -0.8 percentage point were implemented in FYs 2014, 2015, 2016, and 2017, using standard inflation factors, then the requisite $11 billion would be recouped by the end of the statutory 4-year timeline.[18]

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[11] Pub. L. 112-240, 126 Stat. 2313 (2013).
[12] *Id.* at 2353.
[13] 82 Fed. Reg. at 38008.
[14] Pub. L. 114–10, § 414, 129 Stat. 87, 162-163 (2015).
[15] Pub. L. 114–255, 130 Stat. 1033 (2016).
[16] *Id.* at 1319-1320. *See also* 82 Fed. Reg. at 38008.
[17] 82 Fed. Reg. at 38008.
[18] *Id.*

Consistent with the approach discussed in the FY 2014 rulemaking for recouping the $11 billion required by ATRA § 631, in the FY 2015 IPPS/LTCH PPS final rule[19] and the FY 2016 IPPS/LTCH PPS final rule,[20] the Secretary implemented additional -0.8 percentage point recoupment adjustments to the standardized amount in FY 2015 and FY 2016, respectively. The Secretary estimated that these adjustments, combined with leaving the prior -0.8 percentage point adjustments in place, would recover up to $2 billion in FY 2015 and another $3 billion in FY 2016. When combined with the approximately $1 billion adjustment made in FY 2014, the Secretary estimated that approximately $5 to $6 billion would be left to recover under ATRA § 631 by the end of FY 2016.

In the FY 2017 IPPS/LTCH PPS proposed rule,[21] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under ATRA § 631. For the FY 2017 IPPS/LTCH PPS final rule,[22] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FY 2014 through FY 2017 without exceeding this amount is -1.5 percentage points. Based on those updated estimates by the Office of the Actuary, the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under ATRA § 631.[23]

Once the recoupment required under ATRA § 631 was complete, the Secretary anticipated making a single positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631. However, the Secretary determined that MACRA § 414 (which was enacted on April 16, 2015) replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. In the FY 2017 rulemaking, the Secretary indicated that he would address the adjustments for FY 2018 and later fiscal years in future rulemaking. As noted previously, 21-CCA § 15005, which was enacted on December 13, 2016, amended TMA § 7(b)(1)(B)(iii) (as amended by ATRA § 631 and MACRA § 414) to reduce the adjustment for FY 2018 from a 0.5 percentage point to a 0.4588 percentage point. The Secretary believes the directive under 21-CCA § 15005 is clear and, as a result, in the FY 2018 IPPS/LTCH PPS proposed rule for FY 2018, the Secretary proposed to implement the required +0.4588 percentage point as a permanent adjustment to the standardized amount.[24]

The Final IPPS Rule for FY 2018

In response to the +0.4588 percentage point adjustment, several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FY 2017 under

[19] 79 Fed. Reg. 49853, 49874 (Aug. 22, 2014).
[11] 80 Fed. Reg. 49326, 49345 (Aug. 17, 2015).
[21] 81 Fed. Reg. 24946, 24966 (Apr. 27, 2016)
[22] 81 Fed. Reg. 56761 (Aug. 22, 2016).
[23] *Id.* at 56785.
[24] 82 Fed. Reg. at 38009.

ATRA § 631, which exceeded the estimated adjustment of approximately -0.8 percentage point described in the FY 2014 IPPS/LTCH PPS rulemaking. Commenters contended that, as a result, hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA. They asserted that CMS' proposal to apply a 0.4588 percent positive adjustment for FY 2018 misinterprets the relevant statutory authority, and urged the Secretary to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FY 2018 (*i.e.*, the difference between the -1.5 percentage point adjustment made in FY 2017 and the initial estimate of -0.8 percentage point discussed in the FY 2014 IPPS/LTCH PPS rulemaking). The commenters also urged the Secretary to use his discretion under 42 U.S.C. § 1395ww(d)(5)(I) to increase the FY 2018 adjustment by 0.7 percentage point. Other commenters requested that, despite current law, CMS ensure that adjustments totaling the full 3.9 percentage points withheld under ATRA § 631 be returned.[25]

The Secretary responded by stating that, as discussed in the FY 2017 IPPS/LTCH PPS final rule,[26] CMS had completed the $11 billion recoupment required under ATRA § 631. The Secretary also continued to disagree with commenters who asserted that MACRA § 414 was intended to augment or limit the separate obligation under the ATRA to fully offset $11 billion by FY 2017.[27] Moreover, the Secretary pointed out in the FY 2018 IPPS/LTCH PPS proposed rule, he believes that the directive regarding the applicable adjustment for FY 2018 is clear. While the Secretary had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 requires that he not make the single positive adjustment he intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. The Secretary pointed out that, as noted by the commenters and discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage point adjustment originally estimated in the FY 2014 IPPS/LTCH PPS final rule.[28] Finally, the Secretary notes that 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and that this change was enacted on December 13, 2016, ***after*** CMS had proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under ATRA § 631 in the FY 2017 rulemaking. The Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under 21-CCA § 15005.[29]

Providers' Requests for Hearing and EJR

The Providers believe that the 0.7 percent reduction in the standardized amount is excess of the Secretary's authority in 42 U.S.C. § 1395ww. The Secretary did not cite any statutory support

[25] *Id.*
[26] 81 Fed. Reg. 56783-85.
[27] *Id.* at 56784.
[28] 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013).
[29] 82 Fed. Reg. at 38009.

for the 0.7 percent reduction rate for FY 2018. Accordingly, the Providers assert the rate reduction is in excess of the Secretary's statutory authority. The statutory chronology, above, demonstrates that the entire adjustment originally was required to be eliminated through a one-time adjustment in FY 2018. Subsequently, in light of the need for savings to offset the reform of the sustainable growth rate for Medicare physician payment required by MACRA, Congress instructed the Secretary to delay the FY 2018 restoration of the estimated 3.2 percentage point negative adjustments created by ATRA by implementing a schedule of restorative adjustments over 6 years. MACRA was enacted before CMS proposed increasing the planned ATRA adjustment for FY 2017, and Congress expressly provided that the adjustment being delayed was "estimated to be an increase of 3.2 percent." Congress then enacted 21-CCA in FY 2017, further reducing the FY 2018 standard adjustment by 0.0412 percentage points. However, the Providers point out, Congress did not amend the statute to reference the final ATRA adjustment of 3.9 percent. Instead, Congress left in the statement that the adjustment was estimated to be 3.2 percent.

Further, the Providers note, in the FY 2018 IPPS final rule, the Secretary indicated that MACRA and 21-CCA require him to make a positive adjustment of only 0.4588 percentage points to the standardized amount for FY 2018, with additional adjustments of only 0.5 percent in each of the next five years. Thus, the Secretary never restores the 0.7 percent excess ATRA adjustment implemented in FY 2017 and by FY 2023, the Providers believe the financial impact to hospitals of the annual 0.7 percent reduction to the IPPS base rate is roughly $900 million per year, or about $200,000 per Medicare-participating hospital on average, through FY 2023, if not beyond. The Providers assert that the Secretary erroneously interprets the MACRA as requiring a continued additional 0.7 percent ATRA adjustment in FY 2018.

The Providers contend that the rate reduction is arbitrary, capricious, an abuse of discretion or not otherwise in accordance with the law. The Providers believe that the rate reduction is not supported by Congressional intent. They point out that the Congressional Budget Office ("CBO") score of 21-CCA § 15005 reveals an impact well below the amount that would justify a rate reduction in the amount of 0.7 percent and Congress enacted the legislation based on that score. Thus, the rate reduction belies the intent of Congress by imposing a reduction substantially beyond the amount of the CBO score. Further, the Providers assert, since the reduction is at odds with the CBO score, the rate reduction is not supported by substantial evidence and is unwarranted by the facts.

In addition, the Providers argue, the Secretary failed to properly take into account comments made when the proposed IPPS rules were issued which were contrary to the assertions in that rules. The Providers dispute the Secretary's interpretation of the applicable statutory authority. Second, they assert that the Secretary has not furnished the factual basis for denying the comment that "hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA."

Decision of the Board

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply with the 0.7 percent reduction to the IPPS standard amount for FY 2018 as published in the FY 2018 IPPS Final Rule on August 14, 2017 because CMS clearly intended to bind all hospitals, which are subject to IPPS, to this payment reduction and, as such, it is an uncodified regulation adopted through the Federal Register rulemaking process. Accordingly, the Board concludes that it lacks the authority to grant the relief sought by the Providers, to reverse or otherwise invalidate the negative adjustment of 0.7 percent to the IPPS standard amount for FY 2018 as published in the FY 2018 IPPS Final Rule. Consequently, the Board hereby grants the Providers' request for EJR for the issue and federal fiscal year under dispute. Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

In these cases, the Providers filed timely appeals of the FY 2018 IPPS Final Rule as published in the Federal Register on August 14, 2017[30] and the amount in controversy exceeds the $50,000 threshold for jurisdiction over each group.[31] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

The Board finds that:

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

2) Based upon the participants' assertions regarding the 0.7 percent reduction to the IPPS standardized amount, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the 0.7 percent reduction to the FY 2018 IPPS standardized amount as published in the FY 2018 IPPS Final Rule is valid.

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[30] In accordance with the Administrator's decision in *District of Columbia Hospital Association Wage Index Group Appeal*, (HCFA Adm. Dec. January 15, 1993) *Medicare & Medicaid Guide* (CCH) ¶ 41,025, a notice published in the Federal Register is a final determination.

[31] *See* 42 C.F.R. § 405.1837.

Accordingly, the Board finds that the question of the validity of the 0.7 percent reduction to the FY 2018 rate as published in the FY 2018 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby finds that EJR is appropriate for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

Board Members Participating:

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

FOR THE BOARD:

10/17/2019

X Charlotte F. Benson

Charlotte F. Benson, CPA
Board Member
Signed by: Charlotte Benson -A

Enclosure: Schedules of Providers

cc: Byron Lamprecht, WPS
Cecile Huggins, Palmetto GBA
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Kenneth Marcus, Esq.
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RE: ***Expedited Judicial Review Determination***
19-0279G Honigman Miller FFY 2019 Michigan Hospitals FY 2019 ATRA 0.7% IPPS Reduction Group
19-0283GC Trinity Health ATRA 2019 0.7% Reduction Group
19-0289GC Baptist Memorial FFY 2019 0.7% ATRA Reduction CIRP Group

Dear Mr. Marcus:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' September 18, 2019 request for expedited judicial review ("EJR") for the FYs 2018-2019 MS-DRG Documentation and Coding Adjustment issue.[1] The above-captioned groups appealed from the final rule addressing the inpatient prospective payment system for federal fiscal year 2019 that was published on August 17, 2018 ("FY 2019 IPPS Final Rule").[2] The Board decision determining that EJR for FY 2019 is appropriate for the issue and federal fiscal year under appeal is set forth below.

Issue in Dispute

The issue before the Board for the FY 2019 IPPS Final Rule is:

> Whether the action of the [Secretary of the Department of Health and Human Services] imposing a 0.7% reduction . . . in the Medicare Inpatient Prospective Payment System ("IPPS") standardized amount is consistent with applicable law.[3]

[1] This EJR decision ***only*** addresses FY 201**9**. The Board is concurrently issuing an EJR decision for the three FY 2018 group appeals under separate cover as these FY 2018 groups are appealing a different CMS determination covering FY 2018.
[2] 83 Fed. Reg. 41144 (Aug. 17, 2018).
[3] EJR request at 1.

Statutory and Regulatory Background

In the federal year ("FY") 2008 inpatient prospective payment system ("IPPS") final rule,[4] the Secretary[5] adopted the Medicare severity diagnosis-related group ("MS–DRG") patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The Secretary maintains that, by increasing the number of MS–DRGs and more fully taking into account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs would encourage hospitals to improve their documentation and coding of patient diagnoses.[6]

In the FY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs could potentially cause an increase in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FY 2008, -1.8 percent for FY 2009, and -1.8 percent for FY 2010.[7]

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 ("TMA").[8] TMA § 7(a) reduced the documentation and coding adjustment made as a result of the MS–DRG system that the Secretary adopted in the FY 2008 IPPS final rule to -0.6 percent for FY 2008 and -0.9 percent for FY 2009.[9]

The Secretary implemented a series of adjustments required under TMA §§ 7(b)(1)(A) and 7(b)(1)(B) based on a retrospective review of FY 2008 and FY 2009 claims data. The Secretary completed these adjustments in FY 2013. However, the Secretary commented in the FY 2013 IPPS final rule that delaying full implementation of the adjustment required under TMA § 7(b)(1)(A) until FY 2013 had resulted in payments in FY 2010 through FY 2012 being overstated, and that these resulting overpayments could not be recovered.[10]

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[4] 72 Fed. Reg. 47130, 47140 through 47189 (Aug. 22, 2007).
[5] of the Department of Health and Human Services.
[6] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).
[7] *See* 82 Fed. Reg. 37990, 38008 (Aug. 17, 2017).
[8] Pub. L. 110–90, 121 Stat. 984 (2007).
[9] *Id.* at 986.
[10] *See* 82 Fed. Reg. at 38008.

Congress revisited TMA § 7(b)(1)(B) as part of the American Taxpayer Relief Act of 2012 ("ATRA").[11] Specifically, ATRA § 631 amended TMA § 7(b)(1)(B) to add clause (ii) which required the Secretary to make a recoupment adjustment or adjustments totaling $11 billion for discharges occurring during FYs 2014 to 2017. Per the revisions made by ATRA § 631(b), this adjustment "represents the amount of the increase in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied" (*i.e.*, represents the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under TMA § 7(b)(1)(A) until FY 2013).[12] As discussed above, this delay in implementing TMA § 7(b)(1) resulted in overstated payment rates in FYs 2010, 2011, and 2012 and the resulting overpayments could not have been recovered under the original TMA § 7(b).

The adjustment required under ATRA § 631 was a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, the Secretary "anticipated that any adjustment made to reduce payment rates in one year would eventually be offset by a positive adjustment in FY 2018, once the necessary amount of overpayment was recovered."[13]

However, Congress again stepped in to revise TMA § 7(b)(1)(B). First, in § 414 of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Congress revised TMA § 7(b)(1)(B) to add clause (iii) which replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023.[14] Second, in § 15005 of the 21st Century Cures Act ("21-CCA"),[15] Congress amended the MACRA revision in TMA § 7(b)(1)(B)(iii) by reducing the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points.[16]

The Secretary's actuaries "estimated that a -9.3 percentage point adjustment to the standardized amount would be necessary if CMS were to fully recover the $11 billion recoupment required by [ATRA § 631] in FY 2014." Consistent with the policies that the Secretary has adopted in many similar situations, the Secretary implemented a phased in approach. For the first year, FY 2014, he implemented a -0.8 percentage point recoupment adjustment to the standardized amount. The Secretary declined, at that time, to set specific adjustments for FYs 2015, 2016, or 2017 "[a]s estimates of any future adjustments are subject to variations in total savings."[17] However, he did "estimate[]" that, if adjustments of -0.8 percentage point were implemented in FYs 2014, 2015, 2016, and 2017, using standard inflation factors, then the requisite $11 billion would be recouped by the end of the statutory 4-year timeline.[18]

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[11] Pub. L. 112-240, 126 Stat. 2313 (2013).
[12] *Id.* at 2353.
[13] 82 Fed. Reg. at 38008.
[14] Pub. L. 114–10, § 414, 129 Stat. 87, 162-163 (2015).
[15] Pub. L. 114–255, 130 Stat. 1033 (2016).
[16] *Id.* at 1319-1320. *See also* 82 Fed. Reg. at 38008.
[17] 82 Fed. Reg. at 38008.
[18] *Id.*

Consistent with the approach discussed in the FY 2014 rulemaking for recouping the $11 billion required by ATRA § 631, in the FY 2015 IPPS/LTCH PPS final rule[19] and the FY 2016 IPPS/LTCH PPS final rule,[20] the Secretary implemented additional -0.8 percentage point recoupment adjustments to the standardized amount in FY 2015 and FY 2016, respectively. The Secretary estimated that these adjustments, combined with leaving the prior -0.8 percentage point adjustments in place, would recover up to $2 billion in FY 2015 and another $3 billion in FY 2016. When combined with the approximately $1 billion adjustment made in FY 2014, the Secretary estimated that approximately $5 to $6 billion would be left to recover under ATRA § 631 by the end of FY 2016.

In the FY 2017 IPPS/LTCH PPS proposed rule,[21] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under ATRA § 631. For the FY 2017 IPPS/LTCH PPS final rule,[22] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FY 2014 through FY 2017 without exceeding this amount is -1.5 percentage points. Based on those updated estimates by the Office of the Actuary, the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under ATRA § 631.[23]

Once the recoupment required under ATRA § 631 was complete, the Secretary anticipated making a single positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631. However, the Secretary determined that MACRA § 414 (which was enacted on April 16, 2015) replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. In the FY 2017 rulemaking, the Secretary indicated that he would address the adjustments for FY 2018 and later fiscal years in future rulemaking. As noted previously, 21-CCA § 15005, which was enacted on December 13, 2016, amended TMA § 7(b)(1)(B)(iii) (as amended by ATRA § 631 and MACRA § 414) to reduce the adjustment for FY 2018 from a 0.5 percentage point to a 0.4588 percentage point. The Secretary believes the directive under 21-CCA § 15005 is clear and, as a result, in the FY 2018 IPPS/LTCH PPS proposed rule for FY 2018, the Secretary proposed to implement the required +0.4588 percentage point as a permanent adjustment to the standardized amount.[24]

[19] 79 Fed. Reg. 49853, 49874 (Aug. 22, 2014).
[11] 80 Fed. Reg. 49326, 49345 (Aug. 17, 2015).
[21] 81 Fed. Reg. 24946, 24966 (Apr. 27, 2016)
[22] 81 Fed. Reg. 56761 (Aug. 22, 2016).
[23] *Id.* at 56785.
[24] 82 Fed. Reg. at 38009.

The Final IPPS Rule for FY 2018

In response to the +0.4588 percentage point adjustment, several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FY 2017 under ATRA § 631, which exceeded the estimated adjustment of approximately -0.8 percentage point described in the FY 2014 IPPS/LTCH PPS rulemaking. Commenters contended that, as a result, hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA. They asserted that CMS' proposal to apply a 0.4588 percent positive adjustment for FY 2018 misinterprets the relevant statutory authority, and urged the Secretary to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FY 2018 (*i.e.*, the difference between the -1.5 percentage point adjustment made in FY 2017 and the initial estimate of -0.8 percentage point discussed in the FY 2014 IPPS/LTCH PPS rulemaking). The commenters also urged the Secretary to use his discretion under 42 U.S.C. § 1395ww(d)(5)(I) to increase the FY 2018 adjustment by 0.7 percentage point. Other commenters requested that, despite current law, CMS ensure that adjustments totaling the full 3.9 percentage points withheld under ATRA § 631 be returned.[25]

The Secretary responded by stating that, as discussed in the FY 2017 IPPS/LTCH PPS final rule,[26] CMS had completed the $11 billion recoupment required under ATRA § 631. The Secretary also continued to disagree with commenters who asserted that MACRA § 414 was intended to augment or limit the separate obligation under the ATRA to fully offset $11 billion by FY 2017.[27] Moreover, the Secretary pointed out in the FY 2018 IPPS/LTCH PPS proposed rule, he believes that the directive regarding the applicable adjustment for FY 2018 is clear. While the Secretary had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 requires that he not make the single positive adjustment he intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. The Secretary pointed out that, as noted by the commenters and discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage point adjustment originally estimated in the FY 2014 IPPS/LTCH PPS final rule.[28] Finally, the Secretary notes that 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and that this change was enacted on December 13, 2016, ***after*** CMS had proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under ATRA § 631 in the FY 2017 rulemaking. The Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under 21-CCA § 15005.[29]

[25] *Id.*
[26] 81 Fed. Reg. 56783-85.
[27] *Id.* at 56784.
[28] 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013).
[29] 82 Fed. Reg. at 38009.

The FY 2019 Adjustment to the Standardized Amount

In the Final Inpatient PPS Rule for FY 2019,[30] the Secretary finalized a +0.5 percentage point adjustment to the standardized amount for FY 2019, as required under MACRA § 414.

In the final IPPS rule, several commenters argued that the Secretary misinterpreted the Congressional directives regarding the level of positive adjustment required for FY 2018 and FY 2019. The commenters contended that, while the positive adjustments required under MACRA § 414 would only total 3.0 percentage points by FY 2023, the levels of these adjustments were determined using an estimated positive ''3.2 percent baseline'' adjustment that otherwise would have been made in FY 2018. The commenters believed that, because CMS implemented an adjustment of -1.5 percentage points instead of the expected -0.8 percentage points in FY 2017, totaling -3.9 percentage points overall, the Secretary has imposed a permanent -0.7 percentage point negative adjustment beyond its statutory authority, contravening what the commenters contend was Congress' clear instructions and intent. The commenters requested that the Secretary reverse his previous position and implement additional 0.7 percentage point adjustments for both FY 2018 and FY 2019. Some of the commenters requested that the Secretary use his statutory discretion to ensure that all 3.9 percentage points in negative adjustment be restored. In addition, some of the commenters acknowledged that CMS may be bound by law but expressed opposition to the permanent reductions and requested that the Secretary refrain from making any additional coding adjustments in the future.[31]

The Secretary responded by stating that, as discussed in the FY 2019 IPPS/LTCH PPS proposed rule, he believes MACRA § 414 and 21-CCA § 15005 clearly set forth the levels of positive adjustments for FYs 2018 through 2023. He was not convinced that the adjustments prescribed by MACRA were predicated on a specific ''baseline'' adjustment level. While he had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 required that a 0.5 percentage point positive adjustment be implemented for each of FYs 2018 through 2023, rather than the single positive adjustment he had anticipated making in FY 2018. As discussed in the FY 2017 IPPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage points adjustment originally estimated in the FY 2014 IPPS final rule.[32] Moreover, as discussed in the FY 2018 IPPS final rule, 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and this adjustment was enacted on December 13, 2016, ***after*** the Secretary had proposed and finalized the final negative -1.5 percentage points adjustment required under ATRA § 631. The Secretary does not believe that Congress enacted these adjustments with the

[30] 83 Fed. Reg. 41144 (Aug. 17, 2018).
[31] *Id.* at 41157.
[32] 78 Fed. Reg.at 50515.

intent that there would be an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017.[33]

Providers' Requests for Hearing and EJR

The Providers believe that the 0.7 percent reduction in the standardized amount is excess of the Secretary's authority in 42 U.S.C. § 1395ww. The Secretary did not cite any statutory support for the 0.7 percent reduction rate for FY 2018 and thereafter. Accordingly, the Providers assert the rate reduction is in excess of the Secretary's statutory authority. The statutory chronology, above, demonstrates that the entire adjustment originally was required to be eliminated through a one-time adjustment in FY 2018. Subsequently, in light of the need for savings to offset the reform of the sustainable growth rate for Medicare physician payment required by MACRA, Congress instructed the Secretary to delay the FY 2018 restoration of the estimated 3.2 percentage point negative adjustments created by ATRA by implementing a schedule of restorative adjustments over 6 years. MACRA was enacted before CMS proposed increasing the planned ATRA adjustment for FY 2017, and Congress expressly provided that the adjustment being delayed was "estimated to be an increase of 3.2 percent." Congress then enacted 21-CCA in FY 2017, further reducing the FY 2018 standard adjustment by 0.0412 percentage points. However, the Providers point out, Congress did not amend the statute to reference the final ATRA adjustment of 3.9 percent. Instead, Congress left in the statement that the adjustment was estimated to be 3.2 percent.

Further, the Providers note that, in the FY 2018 IPPS final rule, the Secretary indicated that MACRA and 21-CCA require him to make a positive adjustment of only 0.4588 percentage points to the standardized amount for FY 2018, with additional adjustments of only 0.5 percent in each of the next five years. Thus, the Secretary never restores the 0.7 percent excess ATRA adjustment implemented in FY 2017 and by FY 2023, the Providers believe the financial impact to hospitals of the annual 0.7 percent reduction to the IPPS base rate is roughly $900 million per year, or about $200,000 per Medicare-participating hospital on average, through FY 2023, if not beyond. The Providers assert that the Secretary erroneously interprets the MACRA as requiring a continued additional 0.7 percent ATRA adjustment in FY 2018 and subsequent years, including FY 2019. Finally, the Providers assert that, in the FY 2019 IPPS Final Rule, CMS improperly continued the 0.7 percent reduction in the IPPS standardized amount for FY 2019.

The Providers contend that the rate reduction is arbitrary, capricious, an abuse of discretion or not otherwise in accordance with the law. The Providers believe that the rate reduction is not supported by Congressional intent. They point out that the Congressional Budget Office ("CBO") score of 21-CCA § 15005 reveals an impact well below the amount that would justify a rate reduction in the amount of 0.7 percent and Congress enacted the legislation based on that score. Thus, the rate reduction belies the intent of Congress by imposing a reduction substantially beyond the amount of the CBO score. Further, the Providers assert, since the

[33] 83 Fed. Reg. at 41157.

reduction is at odds with the CBO score, the rate reduction is not supported by substantial evidence and is unwarranted by the facts.

In addition, the Providers argue, the Secretary failed to properly take into account comments made when the proposed IPPS rules were issued which were contrary to the assertions in that rules. The Providers dispute the Secretary's interpretation of the applicable statutory authority. Second, they assert that the Secretary has not furnished the factual basis for denying the comment that "hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA."

Decision of the Board

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply with the 0.7 percent reduction to the IPPS standard amount for FY 2019 as published in the 2019 IPPS Final Rule on August 17, 2018 because CMS clearly intended to bind all hospitals, which are subject to IPPS, to this payment reduction and, as such, it is an uncodified regulation adopted through the Federal Register rulemaking process. Accordingly, the Board concludes that it lacks the authority to grant the relief sought by the Providers, to reverse or otherwise invalidate the negative adjustment of 0.7 percent to the IPPS standard amount for FY 2019 as published in the FY 2019 IPPS Final Rule. Consequently, the Board hereby grants the Providers' request for EJR for the issue and federal fiscal year under dispute. Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

In these cases, the Providers filed timely appeals of the FY 2019 IPPS Final Rule as published in the Federal Register on August 17, 2018[34] and the amount in controversy exceeds the $50,000 threshold for jurisdiction over each group.[35] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

The Board finds that:

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

[34] In accordance with the Administrator's decision in *District of Columbia Hospital Association Wage Index Group Appeal*, (HCFA Adm. Dec. January 15, 1993) *Medicare & Medicaid Guide* (CCH) ¶ 41,025, a notice published in the Federal Register is a final determination.
[35] *See* 42 C.F.R. § 405.1837.

2) Based upon the participants' assertions regarding the 0.7 percent reduction to the IPPS standardized amount, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the 0.7 percent reduction to the FY 2019 IPPS standardized amount as published in the FY 2019 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the 0.7 percent reduction to the FY 2019 IPPS rate as published in the FY 2019 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby finds that EJR is appropriate for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

Board Members Participating:

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

FOR THE BOARD:

10/17/2019

X Charlotte F. Benson

Charlotte F. Benson, CPA
Board Member
Signed by: Charlotte Benson -A

Enclosure: Schedules of Providers

cc: Byron Lamprecht, WPS
Cecile Huggins, Palmetto GBA
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Electronic Delivery

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

RE: *Jurisdictional Decision*
Parkview Medical Center (Provider No. 06-0020)
FYE 06/30/2012
PRRB Case No. 15-2270

Dear Mr. Ravindran and Mr. Lattimore,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the jurisdictional documents in this appeal. The Board's jurisdictional decision is set forth below.

Background:

Parkview Medical Center (the "Provider") appealed an original Notice of Program Reimbursement (NPR) dated October 14, 2014 for its fiscal year end (FYE) June 30, 2012 cost reporting period. On April 17, 2015, the Provider filed an individual appeal request which contained seven issues. Five issues were transferred to group appeals, and the Disproportionate Share Hospital ("DSH") Medicaid Eligible Days issue was withdrawn on July 24, 2019.

The Medicare Contractor filed a Jurisdictional Challenge (May 31, 2018) regarding Issue No. 1 addressing the DSH Supplemental Security Income ("SSI") Percentage (Provider Specific) issue, which is the only remaining issue in the appeal.

Medicare Contractor's Position

The Medicare Contractor contends that the DSH SSI Percentage (Provider Specific) issue is the same as Issue No. 2, DSH SSI Percentage (Systemic Errors) which has been transferred to group Case No. 15-1416G. The Medicare Contractor claims an erroneous DSH SSI Percentage is the underlying dispute in both Issue No. 1 and Issue No. 2. The Medicare Contractor also argues that it has made no final determination regarding the portion of Issue No. 1 preserving the right for the

Provider to request that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. As the right to a Board hearing derives from specific items claimed for a cost reporting period covered by a medicare contractor final determination, the Medicare Contractor's position is that a DSH SSI Percentage realignment issue is premature. The Medicare Contactor asks the Board to dismiss Issue No. 1 addressing DSH SSI Percentage (Provider Specific) as it is duplicative of Issue No. 2.

Provider's Position

The Provider filed a Jurisdictional Response (June 27, 2018) in which they contend the Board has jurisdiction over the DSH SSI Percentage (Provider Specific) issue in this appeal. The Provider claims that the DSH SSI Percentage (Provider Specific) issue is a different from the DSH SSI Percentage (Systemic Errors) issue, and that the DSH SSI Percentage (Provider Specific) was adjusted during the audit. The Provider's position is that the Board has jurisdiction over this issue.

Board Decision

The Board finds that it does not have jurisdiction over Issue No. 1 regarding DSH/SSI Percentage (Provider Specific) issue.

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

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

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue that was transferred to Case No. 15-1416G on October 14, 2015.

The DSH SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage

in the Disproportionate Share Hospital Calculation."[1] The Provider's legal basis for its DSH SSI (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[2] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed…" and it "…specifically disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[3]

The Provider's DSH SSI Percentage (Systemic Errors) issue in group Case No. 15-1416G also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106. Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage (Systemic Errors) issue in Case No. 15-1416G. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5 (2015), the Board dismisses this aspect of the DSH SSI Percentage (Provider Specific) issue.

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment.

The appeal is now closed as the last remaining issue, DSH SSI Percentage (Provider Specific) is dismissed in entirety.

[1] *Model Form A – Individual Appeal Request* (Apr. 16, 2015) at Tab 3, Issue 1.
[2] *Id.*
[3] *Id.*

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

Board Members

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

FOR THE BOARD

10/18/2019

X Gregory H. Ziegler

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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PRRB Case No. 14-1627

Richard Wisniewski
Reimbursement Coordinator
Saint Vincent Hospital
232 West 25th Street
Erie, PA 16544

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

RE: Jurisdictional Determination
Saint Vincent Hospital
Provider No.: 39-0009
FYE: June 30, 2010
PRRB Case No.: 14-1627

Dear Mr. Wisniewski and Mr. Snyder:

This case involves Saint Vincent Hospital's ("Provider") appeal of its Medicare reimbursement for the fiscal year ending ("FYE") on June 30, 2010. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed Provider's documentation in response to the Medicare Contractor's September 17, 2019 Jurisdictional Challenge. Following review of the documentation, the Board finds that Provider's Issue 1 and Issue 2 are the same issue and that Provider's Issues 1 and 2 challenge the same underlying Supplemental Security Income ("SSI") data as in Provider's Issue 3. The Board, therefore, dismisses Provider's Issues 1 and 2 from the instant appeal. The Board's findings and jurisdictional determinations are explained below.

PERTINENT FACTS

On January 6, 2014, the Board received Provider's Request for Hearing ("RFH") regarding its July 26, 2013 Notice of Program Reimbursement ("NPR") for the cost reporting period ending on June 30, 2010. In its RFH, Provider initially challenged seven issues, but after transferring some of the issues and withdrawing one, the instant appeal is left with three issues—an SSI Provider-Specific issue that includes a request for realignment (Issue 1), an SSI Provider-Specific issue without a request for realignment (Issue 2) and a Medicaid eligible days issue (Issue 4).

On September 17, 2019, the Board received the Medicare Contractor's Jurisdictional Challenge in which the Contractor claims that Provider's Issues 1 and 2 are the same and that the Issues 1 and 2 are duplicative of Provider's Issue 3 which was transferred to a group appeal.

BOARD'S ANALYSIS AND DECISION

A. Applicable Regulatory Provisions and Board Rules

Pursuant to 42 C.F.R. §§ 405.1835-405.1840 (2013), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare Contractor, the amount in controversy is $10,000 or more, and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2010), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Under Board Rule 4.6.1 (August 29, 2018),[1] a provider may not appeal an issue from a single final determination in more than one appeal.

B. Analysis

1. Issues 1 and 2

Within its RFH, Provider challenges its SSI percentage in its first three issues. For Issues 1 and 2, Provider has set out the exact same issue statement with the exception of one sentence. The first part of both issue statements reads, in pertinent part:

> The Provider contends that its[] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
> The Provider contends that the SSI percentage issued by CMS is flawed.
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage.[2]

Issue 1's Issue Statement also contains the Provider's declaration that it "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[3] In Issue 2's Issue Statement, Provider proclaims that "upon completion of this review it will be entitled to a correction of these errors of omission to its[] SSI percentage based on CMS's admission that errors occurred that did not account for all patient days in the Medicare fraction."[4]

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[1] Formerly, Board Rule 4.5 (July 1, 2009).
[2] RFH TAB 3 at unnumbered pages 1-2.
[3] *Id.*
[4] *Id*. at 1-2.

The Board notes that although Issue 1 includes a potential request for realignment of Provider's SSI percentage, under the pertinent regulations,[5] such a request is a provider election and not an appealable issue. Thus the Board finds that Provider's Issue 1 and 2 are the same issue for purposes of the remainder of this jurisdictional determination.

2. Issue 3

Within its RFH, Provider describes its Issue 3 in the following manner: "[t]he Provider contends that the SSI percentages calculated by [CMS] . . . [were] incorrectly computed because of the following reasons": (1) the availability of MEDPAR and SSA records, (2) paid days v. eligible days, (3) not in agreement with Provider's records, (4) fundamental problems in the SSI percentage calculation, (5) covered days v. total days, (6) non-covered days, (7) CMS Ruling 1498-R and (6) failure to adhere to required notice and comment rulemaking procedures.[6]

On August 27, 2014, Provider transferred Issue 3 to a group appeal, PRRB Case No. 14-1815G.

C. Decision

In its Issue 1 Issue Statement, Provider claims that "CMS failed to include all patients that were entitled to SSI benefits in their calculation[,]" whereas in its Issue 3 Issue Statement, Provider sets out a more detailed list of reasons why it claims that certain patients were not included in its SSI percentage. Provider, however, fails to describe additional reasons or patient populations "entitled to SSI benefits" that would distinguish the issues or in any way differentiate the underlying data being challenged. The Board concludes, therefore, that Provider's Issue 1 and its Issue 3 challenge the same underlying SSI data and are, ultimately, the same issue.

Provider impermissibly has the same issue from a single final determination in two separate appeals,[7] thus the Board hereby dismisses Provider's Issues 1 and 2 from the instant appeal. As Provider previously transferred its Issue 3 to a group appeal, PRRB Case No. 14-1815G, Provider's challenge to its underlying SSI data remains open within the group appeal.

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

Board Members Participating:
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
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Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

10/18/2019

X Gregory H. Ziegler

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

[5] 42 C.F.R. § 412.106(b)(3).
[6] RFH TAB 3 at unnumbered pages 2-10.
[7] *See* Board Rule 4.6.1 (August 29, 2018).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Maureen O'Brien Griffin, Esq.
Hall, Render, Killian, Heath & Lyman
500 North Meridian St., Ste. 400
Indianapolis, IN 46204

RE: ***Expedited Judicial Review Determination***
Premier Health Partners pre 10/1/2013 DSH Medicare-Medicaid Part C Days Group
Case No. 16-1519GC

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' September 25 request for expedited judicial review ("EJR") for the appeal referenced above.[1] The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in this appeal is:

> The improper inclusion by the [Medicare Contractor] and the Centers for Medicare & Medicaid Services (CMS) of inpatient days attributable to Medicare Advantage patients in the numerator and [denominator] of the Medicare Proxy when calculating the disproportionate share hospital (DSH) eligibility and payments.[2]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] The Board bifurcated this appeal which contains the period 1/1/2013 through 9/30/2013. The period 10/1/2013 through 12/31/2013 is contained in Case No. 20-0085GC.
[2] Providers' EJR Request at 2.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.
[15] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[16] *Id.*
[17] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [18]

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

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

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

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . .* if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated

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Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

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

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

[20] 69 Fed. Reg. at 49099.

> with M+C beneficiaries in the Medicare fraction of the DSH calculation.[21]

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[24] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* (*Allina II*),[26] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[27] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[28] Once again, the Secretary has not acquiesced to this decision.

Providers' Requests for EJR

The Providers assert that that the Medicare fraction of the DSH calculation is improperly understated due to the Secretary's erroneous inclusion of inpatient days attributable to Medicare Advantage patients in both the numerator and the denominator of the of the Medicare fraction. The failure to include such days in the Medicaid fraction also understated that fraction. The Providers point out that the authority upon which CMS relied to collect Medicare Advantage days information is the DSH regulation at 42 C.F.R. § 412.106, which includes Medicare Advantage days in the description of the days included in the Medicare fraction. However, the

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] 72 Fed. Reg. at 47411.
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.

enabling statute for this regulation, 42 U.S.C. § 1395ww(d)(5)(f), makes no mention of the inclusion of Medicaid Advantage days in the Medicare fraction, only traditional Part A days. The Providers contend that Medicare Advantage beneficiaries are not entitled to benefits under Part A, but instead are entitled to benefits under Part C. As a result, the Providers are challenging the validity of the regulation to the extent that 42 C.F.R. § 412.106 contradicts the enabling statute at 42 U.S.C. § 1395ww(d)(5)(f).[29]

In challenging the validity of the regulation, the Providers assert that the regulation was adopted in violation of the Administrative Procedures Act (APA). They contend that the Secretary violated the APA when she deprived the public the opportunity to comment on the regulation. This position was upheld in the decisions in both *Allina I* and *Allina II*.[30]

The Providers argue that any Medicare Advantage days that are also dual eligible days cannot be counted in the Medicare ratio for the same reasons as set forth above. Primarily, they believe, the regulation requiring inclusion of dual eligible days in the Medicare ratio is invalid and the days must be counted in numerator of the Medicaid fraction. This allegedly improper treatment resulted in the under payment to Providers as DSH eligible providers of services to indigent patients, and includes any other related adverse impact to DHS payments, such as capital DSH payments.[31]

With respect to EJR, the Providers believe that the Board has jurisdiction over the matter at issue and lacks the legal authority to decide the legal question presented. The Providers posit that the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the APA and the statute and is bound by Secretary's actions. The Providers do not believe that the Board has the authority to implement the effect of *Allina I.*

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeal within this EJR request have filed appeals involving fiscal 2013 but only that portion through September 30, 2013.[32]

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[29] *Id.* at 2.
[30] *Id.*
[31] *Id.*
[32] *See supra* note 1.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[33] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[34]

On August 21, 2008, new regulations governing the Board were effective.[35] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[36] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[37]

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

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[33] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[34] *Bethesda,* 108 S. Ct. at 1258-59.
[35] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[36] 201 F. Supp. 3d 131 (D.D.C. 2016)
[37] *Id.* at 142.

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. The participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[38] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction over the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve FY 2013 but only that portion up through September 30, 2013.[39] Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[40] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[41] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year[42] and that the participants in this group appeal are entitled to a hearing before the Board;

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

10/23/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Judith Cummings, CGS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Maureen O'Brien Griffin, Esq.
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RE: ***EJR Determination for Case No. 19-1219***
Rehoboth McKinley Christian Health Care Services, Provider 32-0038, 12/31/11
Case No. 19-1219

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's September 19, 2019 request for expedited judicial review ("EJR") (received electronically September 23, 2019 and via UPS September 24, 2019) for the above-referenced appeal. The Board's decision with respect to EJR is set forth below.

Issue in Dispute

The issue in dispute in this case is:

> [Whether the Provider] is entitled to the LVA [low volume adjustment] for FYE 2011 as a matter of law as directed by Congress pursuant to the amended LVA statute[,] 42 U.S.C. § 1395ww(d)(12)(C)(iii), and under the principles of equity and fairness due to the MAC's [Medicare Administrative Contractor's] egregious denial of their Reopening filed within the required timeframe.[1]

Background

Pursuant to 42 C.F.R. § 412.101, in order to qualify for the LVA, a provider must have sufficient evidence that: (1) it has fewer than 1,600 total discharges, and (2) it is more than 15 road miles from another subsection (d) hospital under the regulation. The Provider is 64.77 miles from Cibola General Hospital, the nearest IPPS hospital. The Provider states that it had less than 1,600 discharges during the fiscal year under appeal.[2]

[1] Provider's EJR Request at 1.
[2] Provider's EJR request at 2.

On August 16, 2010 the Provider requested an LVA payment for the FY 2011. However, on October 15, 2010, the Medicare Contractor denied the LVA request on the basis that the Provider failed to meet the distance criteria of the LVA regulation. CGS determined that the Provider was not eligible for the LVA because Gallup Indian Medical Center, operated by the Indian Health Service (IHS), was located 0.3 miles from the Provider, and the IHS facility was viewed by CMS as a "subsection (d) hospital. After a change to the Provider's fiscal year end to 12/31/2011, the Medicare Contractor sent an amended letter on December 13, 2011 reiterating its denial for 2011.[3]

On May 13, 2014, the Provider received its original Notice of Program Reimbursement without the LVA payment. On May 4, 2017, the Provider requested its cost report be reopened to correct the alleged material error made when the LVA payment was withheld.[4] The Provider reminded the Medicare Contractor that CMS announced in the Fiscal Year 2018 Medicare Hospital Proposed IPPS[5] Proposed Rule that an IHS or Tribal hospital are not valid treatment options for the general Medicare population that would not be eligible for IHS services. Therefore, the IHS hospital should not be considered in evaluation whether a non-IHS hospital meets the mileage criteria for an LVA.[6] The Provider states that the MAC denied the request to reopen,[7] but did not furnish a copy of the denial.

On August 30, 2018, the Provider sent an email to the Medicare Contractor upon resolution of the same issue for FYs 2012-2014 asking "Any word on how things are looking for 2011".[8] The Medicare Contractor replied the same day via email that they were unable "to do anything on it." Then, in an email dated November 9, 2018, the Provider again requested that the MAC reopen the cost report and pay the Provider an LVA. On the same day the Intermediary replied back to the email stating that CMS informed them that they could not reopen. The email stated:

> [The MAC] cannot do a reopening for the 2011 cost report. Our direction from CMS [the Centers for Medicare & Medicaid Services] was to reopen and allow the LVA payment that are within 3 years of the NPR, 3 years from the [LVA] denial, or are currently under appeal. The FYE 2011 cost report does not fall into any of these categories. The NPR was dated 5/13/2014, the LVA decision was made 12/31/2011 and the reopening request that you refer to was denied as we could not resolve the issue at that time.[9]

The Provider appealed the August 30, 2018 email "denial" by the Medicare Contractor, and included the email exchange as its final determination.

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[3] *Id.*
[4] Provider's EJR request Ex. P-1.
[5] Inpatient Prospective Payment System
[6] 82 Fed. Reg. 19196, 19939 (Apr. 28, 2017).
[7] Provider's EJR request at 2.
[8] Exhibit P-2 at 3.
[9] Provider's EJR request at Ex. P-2.

Decision of the Board

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

Jurisdiction

Pursuant to 42 C.F.R. § 405.1885(a)(6), a determination or decision to reopen or not to reopen a determination or decision is not a final determination or decision within the meaning of this subpart and is not subject to further administrative review or judicial review. Consequently, the Board finds that the Medicare Contractor's August 30, 2018 refusal to reopen the cost report, which was appealed in this case, is not reviewable. As a consequence, the Board lacks jurisdiction over the appeal and dismisses the case.[10] Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Provider's request for EJR is hereby denied.[11] As this is the only issue in the appeal, the Board hereby closes the case. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
Clayton J. Nix, Esq.
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Susan A. Turner, Esq.

FOR THE BOARD:

10/23/2019

X Clayton J. Nix

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

cc: Judith Cummings, CGS
Wilson Leong, FSS

[10] *See also Your Home Visiting Nurse Service, Inc. v. Shalala*, 119 S.Ct. 930 (1999).
[11] *See* 42 C.F.R. § 405.1842(a).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
18-1744G Hall Render CY 2013 DSH Medicare/Medicaid Fraction MA Days IV Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' October 3, 2019, Request for Expedited Judicial Review ("EJR") for the appeal referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

> Whether Medicare Advantage Days ("Part C days") should be removed from the disproportionate share hospital adjustment ("DSH adjustment") Medicare fraction and added to the Medicaid Fraction.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's

[1] Request for Expedited Judicial Review Determination, Issue Statement, at 1 (Oct. 3, 2019), 18-1744G.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).

qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

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

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

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

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

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

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations

[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] (Emphasis added.)
[10] 42 C.F.R. § 412.106(b)(2)-(3).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(4).

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

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

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

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

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

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[13] of Health and Human Services.
[14] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[15] *Id.*
[16] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[17] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

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

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

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

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.[21] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made

[18] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[19] 69 Fed. Reg. at 49099.
[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

"technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[22] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[23]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[24] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* (*Allina II),*[26] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[27] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[28] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

The Providers assert that that the Medicare fraction of the DSH calculation is improperly understated due to the Secretary's erroneous inclusion of inpatient days attributable to Medicare Advantage patients in both the numerator and the denominator of the of the Medicare fraction. The failure to include such days in the Medicaid fraction also understated that fraction. The Providers point out that the authority upon which CMS relied to collect Medicare Advantage days information is the DSH regulation at 42 C.F.R. § 412.106, which includes Medicare Advantage days in the description of the days included in the Medicare fraction. However, the enabling statute for this regulation, 42 U.S.C. § 1395ww(d)(5)(f), makes no mention of the inclusion of Medicaid Advantage days in the Medicare fraction, only traditional Part A days. The Providers contend that Medicare Advantage beneficiaries are not entitled to benefits under Part A, but instead are entitled to benefits under Part C. As a result, the Providers are

[22] 72 Fed. Reg. at 47411.
[23] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.

challenging the validity of the regulation to the extent that 42 C.F.R. § 412.106 contradicts the enabling statute at 42 U.S.C. § 1395ww(d)(5)(f).[29]

In challenging the validity of the regulation, the Providers assert that the regulation was adopted in violation of the Administrative Procedures Act (APA). They contend that the Secretary violated the APA when she deprived the public the opportunity to comment on the regulation. This position was upheld in the decisions in both *Allina I* and *Allina II.*[30]

The Providers argue that any Medicare Advantage days that are also dual eligible days cannot be counted in the Medicare ratio for the same reasons as set forth above. Primarily, they believe, the regulation requiring inclusion of dual eligible days in the Medicare ratio is invalid and the days must be counted in numerator of the Medicaid fraction. This allegedly improper treatment resulted in the under payment to Providers as DSH eligible providers of services to indigent patients, and includes any other related adverse impact to DHS payments, such as capital DSH payments.[31]

With respect to EJR, the Providers believe that the Board has jurisdiction over the matter at issue and lacks the legal authority to decide the legal question presented. The Providers posit that the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the APA and the statute and is bound by Secretary's actions. The Providers do not believe that the Board has the authority to implement the effect of *Allina I.*

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeal within this EJR request have filed appeals involving fiscal year 2013 but only for those portions prior to October 1, 2013 if a participating provider's fiscal year end occurs on or after October 1, 2013.[32]

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of

[29] *Id.* at 2.
[30] *Id.*
[31] *Id.*
[32] For Provider ## 6 and 7, the period on and after 10/1/13 was transferred to Case No. 19-2695G on October 2, 2019.

Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* (*Bethesda)*.[33] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[34]

On August 21, 2008, new regulations governing the Board were effective.[35] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp.l v. Burwell (*"*Banner*").[36] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[37]

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

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[33] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[34] *Bethesda*, 108 S. Ct. at 1258-59.
[35] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[36] 201 F. Supp. 3d 131 (D.D.C. 2016)
[37] *Id.* at 142.

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. The participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[38] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction over the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2013 cost reporting period but only those portions prior to October 1, 2013.[39] Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS Final Rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[40] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[41] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.[42]

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year[43] and that the participants in this group appeal are entitled to a hearing before the Board;

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

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

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[38] *See* 42 C.F.R. § 405.1837.
[39] *See supra* note 31.
[40] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[41] *See* 42 U.S.C. § 1395oo(f)(1).
[42] Wisconsin Physicians Service ("WPS"), filed objections to the EJR requests. In its filings, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.
[43] *See supra* note 31.

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

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

Board Members Participating:

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

For the Board:

10/24/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Mail

Corinna Goron
Healthcare Reimbursement Services, Inc.
17101 Preston Rd., Ste. 220
Dallas, TX 75248

RE: ***Expedited Judicial Review Determination***
19-0963GC Cottage Health FFY 2019 ATRA IPPS 0.7% Rate Reduction CIRP Group
19-0964GC Mount Sinai Health System FFY 2019 ATRA IPPS 0.7% Rate Reduction CIRP
19-0965GC Franciscan Missionaries FFY 2019 ATRA IPPS 0.7% Rate Reduction CIRP Grp.
19-0966GC Health Quest FFY 2019 ATRA IPPS 0.7% Rate Reduction CIRP Group
19-0980GC ProMedica Health FFY 2019 ATRA IPPS 0.7% Rate Reduction CIRP Group
19-0981GC Lafayette General Health FFY 2019 ATRA IPPS 0.7% Rate Reduction CIRP Grp.
19-0985GC UHHS FFY 2019 ATRA IPPS 0.7% Rate Reduction CIRP Group
19-1013GC Prime Healthcare FFY 2019 ATRA IPPS 0.7% Rate Reduction CIRP Group
19-1014GC Loma Linda University FFY 2019 ATRA IPPS 0.7% Rate Reduction CIRP Group
19-1040GC Sisters of Charity Health FFY 2019 ATRA IPPS 0.7% Rate Reduction CIRP Grp.
19-1101G HRS FFY 2019 ATRA IPPS 0.7% Rate Reduction Group
19-1114GC Alecto Healthcare FFY 2019 ATRA IPPS 0.7% Rate Reduction CIRP Group
19-1134GC Cleveland Clinic Foundation FFY 2019 ATRA IPPS 0.7% Rate Reduction CIRP
19-1574G HRS FFY 2019 ATRA IPPS 0.7% Rate Reduction 2 Group

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' September 27, 2019 Request for Expedited Judicial Review ("EJR") and response to the Board's August 29, 2019 notice that it was considering expedited judicial review ("EJR") on its own motion for the FFY 2019 Medicare severity diagnosis-related group ("MS-DRG") documentation and coding adjustment issue.[1] The Board's decision determining that EJR is appropriate for the issue and federal fiscal year ("FFY") under appeal is set forth below.

Issue in Dispute

The Providers are challenging:

> [w]hether CMS acted unlawfully by failing to make a positive adjustment of 0.7% to the Inpatient Prospective Payment System

[1] *See* 42 C.F.R. § 405.1842(c)(d).

> ("IPPS") rates in federal fiscal year ("FFY") 2019 to reverse the effect of a negative adjustment of 0.7% made over fiscal years 2014 through 2017, which has reduced the Providers' Medicare reimbursement in FFY 2019 and will continue to do so in perpetuity.[2]

Statutory and Regulatory Background

In the FFY 2008 IPPS final rule,[3] the Secretary[4] adopted the MS–DRG patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The Secretary believes that, by increasing the number of MS–DRGs and more fully taking into account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs will encourage hospitals to improve their documentation and coding of patient diagnoses.[5]

In the FFY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FFY 2008, -1.8 percent for FFY 2009, and -1.8 percent for FFY 2010.[6]

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 ("TMA").[7] TMA § 7(a) reduced the documentation and coding adjustment made as a result of the MS–DRG system that the Secretary adopted in the FFY 2008 IPPS final rule to -0.6 percent for FFY 2008 and -0.9 percent for FFY 2009.[8]

The Secretary implemented a series of adjustments required under TMA §§ 7(b)(1)(A) and 7(b)(1)(B) based on a retrospective review of FFY 2008 and FFY 2009 claims data. The Secretary completed these adjustments in FFY 2013. However, the Secretary commented in the

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[2] Providers' Response to Board's Own Motion for Expedited Judicial Review at 1.
[3] 72 Fed. Reg. 47130, 47140 through 47189 (Aug. 22, 2007)
[4] of the Department of Health and Human Services.
[5] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).
[6] 82 Fed. Reg. 37990, 38008 (Aug. 17, 2017).
[7] Pub. L. 110–90, 121 Stat. 984 (2007).
[8] *Id.* at 986.

FFY 2013 IPPS final rule that delaying full implementation of the adjustment required under TMA § 7(b)(1)(A) until FFY 2013 had resulted in payments in FFY 2010 through FFY 2012 being overstated, and that these overpayments could not be recovered.[9]

Congress revisited TMA § 7(b)(1)(B) as part of the American Taxpayer Relief Act of 2012 ("ATRA").[10] Specifically, ATRA § 631 amended TMA § 7(b)(1)(B) to add clause (ii) which required the Secretary to make a recoupment adjustment or adjustments totaling $11 billion for discharges occurring during FFYs 2014 to 2017. Per the revisions made by ATRA § 631(b), this adjustment "represents the amount of the increase in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied" (*i.e.*, represents the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under TMA § 7(b)(1)(A) until FY 2013).[11] As discussed above, this delay in implementing TMA § 7(b)(1) resulted in overstated payment rates in FFYs 2010, 2011, and 2012 and the resulting overpayments could not have been recovered under the original TMA § 7(b).

The adjustment required under ATRA § 631 was a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, the Secretary "anticipated that any adjustment made to reduce payment rates in one year would eventually be offset by a positive adjustment in FFY 2018, once the necessary amount of overpayment was recovered."[12]

However, Congress again stepped in to revise TMA § 7(b)(1)(B). First, in § 414 of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Congress revised TMA § 7(b)(1)(B) to add clause (iii) which replaced the single positive adjustment the Secretary intended to make in FFY 2018 with a 0.5 percentage point positive adjustment for each of FFYs 2018 through 2023.[13] Second, in § 15005 of the 21st Century Cures Act ("21-CCA"),[14] Congress amended the MACRA revision in TMA § 7(b)(1)(B)(iii) by reducing the adjustment for FFY 2018 from 0.5 percentage points to 0.4588 percentage points.[15]

The Secretary's "actuaries estimated that a -9.3 percentage point adjustment to the standardized amount would be necessary if CMS were to fully recover the $11 billion recoupment required by

[ATRA § 631] in FFY 2014." Consistent with the policies that the Secretary has adopted in many similar situations, the Secretary implemented a phased in approach. For the first year, FFY 2014, he implemented a -0.8 percentage point recoupment adjustment to the standardized amount. The Secretary declined, at that time, to set specific adjustments for FFYs 2015, 2016, or 2017 "[a]s estimates of any future adjustments are subject to variations in total savings[.]"[16]

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[9] 82 Fed. Reg. at 38008.
[10] Pub. L. 112-240, 126 Stat. 2313 (2013).
[11] *Id.* at 2353.
[12] 82 Fed. Reg. at 38008.
[13] Pub. L. 114–10, § 414, 129 Stat. 87, 162-163 (2015).
[14] Pub. L. 114–255, 130 Stat. 1033 (2016).
[15] *Id.* at 1319-1320. *See also* 82 Fed. Reg. at 38008.
[16] 82 Fed. Reg. at 38008.

However, he did estimate that, if adjustments of -0.8 percentage point were implemented in FFYs 2014, 2015, 2016, and 2017, using standard inflation factors, then the requisite $11 billion would be recouped by the end of the statutory 4-year timeline.[17]

Consistent with the approach discussed in the FFY 2014 rulemaking for recouping the $11 billion required by ATRA § 631, in the FFY 2015 IPPS/LTCH PPS final rule[18] and the FFY 2016 IPPS/LTCH PPS final rule,[19] the Secretary implemented additional -0.8 percentage point recoupment adjustments to the standardized amount in FY 2015 and FY 2016, respectively. The Secretary estimated that these adjustments, combined with leaving the prior -0.8 percentage point adjustments in place, would recover up to $2 billion in FFY 2015 and another $3 billion in FFY 2016. When combined with the approximately $1 billion adjustment made in FY 2014, the Secretary estimated that approximately $5 to $6 billion would be left to recover under ATRA § 631 by the end of FY 2016.

In the FFY 2017 IPPS/LTCH PPS proposed rule,[20] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under ATRA § 631. For the FFY 2017 IPPS/LTCH PPS final rule,[21] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FFY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FFY 2014 through FFY 2017 without exceeding this amount is -1.5 percentage points. Based on those updated estimates by the Office of the Actuary, the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under ATRA § 631.[22]

Once the recoupment required under ATRA § 631 was complete, the Secretary anticipated making a single positive adjustment in FFY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631. However, MACRA § 414 (which was enacted on April 16, 2015) replaced the single positive adjustment the Secretary intended to make in FFY 2018 with a 0.5 percentage point positive adjustment for each of FFYs 2018 through 2023. In the FFY 2017 rulemaking, the Secretary indicated that he would address the adjustments for FFY 2018 and later fiscal years in future rulemaking. As noted previously, 21-CCA § 15005, which was enacted on December 13, 2016, amended TMA § 7(b)(1)(B) (as amended by ATRA § 631 and MACRA § 414) to reduce the adjustment for FFY 2018 from a 0.5 percentage point to a 0.4588 percentage point. The Secretary believes the directive under 21-CCA § 15005 is clear and, as a result, in the FFY 2018 IPPS/LTCH PPS proposed rule for FFY 2018, the Secretary proposed to implement the required +0.4588 percentage point as a permanent adjustment to the standardized amount.[23]

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[17] *Id.*
[18] 79 Fed. Reg. 49853, 49874 (Aug. 22, 2014).
[11] 80 Fed. Reg. 49326, 49345 (Aug. 17, 2015).
[20] 81 Fed. Reg. 24946, 24966 (Apr. 27, 2016)
[21] 81 Fed. Reg. 56761 (Aug. 22, 2016).
[22] *Id.* at 56785.
[23] 82 Fed. Reg. at 38009.

The Final IPPS Rule for FFY 2018

In response to the +0.4588 percentage point adjustment, several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FFY 2017 under ATRA § 631, which exceeded the estimated adjustment of approximately -0.8 percentage point described in the FFY 2014 IPPS/LTCH PPS rulemaking. Commenters contended that, as a result, hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA. They asserted that CMS' proposal to apply a 0.4588 percent positive adjustment for FFY 2018 misinterprets the relevant statutory authority, and urged the Secretary to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FFY 2018 (*i.e.*, the difference between the -1.5 percentage point adjustment made in FY 2017 and the initial estimate of -0.8 percentage point discussed in the FFY 2014 IPPS/LTCH PPS rulemaking). The commenters also urged the Secretary to use his discretion under 42 U.S.C. § 1395ww(d)(5)(I) to increase the FFY 2018 adjustment by 0.7 percentage point. Other commenters requested that, despite current law, CMS ensure that adjustments totaling the full 3.9 percentage points withheld under ATRA § 631 be returned.[24]

The Secretary responded by stating that, as discussed in the FFY 2017 IPPS/LTCH PPS final rule,[25] CMS had completed the $11 billion recoupment required under ATRA § 631. The Secretary also continued to disagree with commenters who asserted that MACRA § 414 was intended to augment or limit the separate obligation under the ATRA to fully offset $11 billion by FFY 2017.[26] Moreover, the Secretary pointed out in the FFY 2018 IPPS/LTCH PPS proposed rule, he believes that the directive regarding the applicable adjustment for FFY 2018 is clear. While the Secretary had anticipated making a positive adjustment in FFY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 requires that he not make the single positive adjustment he intended to make in FFY 2018 but instead make a 0.5 percentage point positive adjustment for each of FFYs 2018 through 2023. The Secretary pointed out that, as noted by the commenters and discussed in the FFY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage point adjustment originally estimated in the FFY 2014 IPPS/LTCH PPS final rule.[27] Finally, the Secretary notes that 21-CCA § 15005 further reduced the positive adjustment required for FFY 2018 from 0.5 percentage point to 0.4588 percentage point and that this change was enacted on December 13,

2016, ***after*** CMS had proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under ATRA § 631 in the FFY 2017 rulemaking. The Secretary finalized

[24] *Id.*
[25] 81 Fed. Reg. 56783-85.
[26] *Id.* at 56784.
[27] 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013).

the +0.4588 percentage point adjustment to the standardized amount for FFY 2018, as required under 21-CCA § 15005.[28]

The FFY 2019 Adjustment to the Standardized Amount

In the Final Inpatient IPPS Rule for FFY 2019,[29] the Secretary finalized a +0.5 percentage point adjustment to the standardized amount for FFY 2019, as required under MACRA § 414.

In the final IPPS rule, several commenters argued that the Secretary misinterpreted the Congressional directives regarding the level of positive adjustment required for FFY 2018 and FFY 2019. The commenters contended that, while the positive adjustments required under MACRA § 414 would only total 3.0 percentage points by FFY 2023, the levels of these adjustments were determined using an estimated positive ''3.2 percent baseline'' adjustment that otherwise would have been made in FFY 2018. The commenters believed that, because CMS implemented an adjustment of -1.5 percentage points instead of the expected -0.8 percentage points in FFY 2017, totaling -3.9 percentage points overall, the Secretary has imposed a permanent -0.7 percentage point negative adjustment beyond its statutory authority, contravening what the commenters contend was Congress' clear instructions and intent. The commenters requested that the Secretary reverse his previous position and implement additional 0.7 percentage point adjustments for both FFY 2018 and FFY 2019. Some of the commenters requested that the Secretary use his statutory discretion to ensure that all 3.9 percentage points in negative adjustment be restored. In addition, some of the commenters acknowledged that CMS may be bound by law but expressed opposition to the permanent reductions and requested that the Secretary refrain from making any additional coding adjustments in the future.[30]

The Secretary responded by stating that, as discussed in the FFY 2019 IPPS/LTCH PPS proposed rule, he believes MACRA § 414 and 21-CCA § 15005 clearly set forth the levels of positive adjustments for FFYs 2018 through 2023. He was not convinced that the adjustments prescribed by MACRA were predicated on a specific ''baseline'' adjustment level. While he had anticipated making a positive adjustment in FFY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 required that a 0.5 percentage point positive adjustment be implemented for each of FFYs 2018 through 2023, rather than the single positive adjustment he had anticipated making in FFY 2018. As discussed in the FFY 2017 IPPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage points adjustment originally estimated in the FFY 2014 IPPS final rule.[31] Moreover, as discussed in the FFY 2018 IPPS final rule, 21-CCA § 15005 further reduced the positive adjustment required for FFY 2018 from 0.5 percentage point to 0.4588 percentage point and this adjustment was enacted on December 13, 2016, ***after***

[28] 82 Fed. Reg. at 38009.
[29] 83 Fed. Reg. 41144 (Aug. 17, 2018).
[30] *Id.* at 41157.
[31] 78 Fed. Reg.at 50515.

the Secretary had proposed and finalized the final negative -1.5 percentage points adjustment required under ATRA § 631. The Secretary does not believe that Congress enacted these adjustments with the intent that there would be an additional +0.7 percentage point adjustment in FFY 2018 to compensate for the higher than expected final ATRA adjustment made in FFY 2017.[32]

Providers' Requests for EJR

The Providers contend that CMS was required by statute to make a 0.7 percent positive adjustment to the standardized amount in FFY 2019 and its refusal to do so was unlawful. The Providers maintain CMS' authority to make the ATRA adjustments comes from TMA § 7(b)(1)(B)(ii), as amended. The Providers assert TMA § 7(b)(2) specifies that any adjustment made under § 7(b)(1)(B) "for discharges occurring in a year shall not be included in the determination of standardized amounts for discharges occurring in a subsequent year." The Providers argue that CMS has violated this directive by failing to make a 0.7 percent curative adjustment in FFY 2019. As a result, CMS will recoup more than $11 billion authorized by ATRA which constitutes, per 5 U.S.C. § 706(2)(C), agency action " in excess of statutory jurisdiction, authority, or limitations, or short of statutory right."

The Providers maintain at a minimum, CMS has discretion under 42 U.S.C. § 1395ww(d)(5)(I) to restore this cut under its power to implement "exceptions and adjustments" to the standardized amount as it deems appropriate. The Providers contend that CMS has committed reversible error by stating in the IPPS Final Rule for FFY 2019 that it did not have the authority to make this curative adjustment. The Providers assert that CMS' error regarding its own authority is reason enough to remand the issue to CMS for further consideration. CMS' failure to act on its authority to restore the act is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with 5 U.S.C. § 706(2)(A), since there is no reasonable basis for maintaining this reduction after the required recoupment has been achieved.

The Providers contend that the Board has jurisdiction over these group appeals pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii). The Providers assert each appeal was filed timely and the aggregate amount in controversy for the appeal is well in excess of $50,000. In addition, the Providers argue that, by challenging both the adoption and the amount of CMS' adjustments in IPPS payment rates effective for FFY 2019, they challenge CMS' determination of the amount of payment under 42 U.S.C. § 1395ww(d) and that they, thereby, meet the dissatisfaction standard. The Providers maintain that it is well settled that publication of the IPPS payment rates in the Federal Register is a final determination that is appealable to the Board pursuant to § 1395oo(a).[33] The Providers argue CMS' refusal to make a 0.7 percent curative adjustment to the standardized amount in FFY 2019 is itself a final determination from which the Providers properly appealed within 180 days of publication pursuant to 42 U.S.C. § 1395oo(a).

[32] 83 Fed. Reg. at 41157.
[33] Providers' September 27, 2019 Response to Board's Own Motion for Expedited Judicial Review at 3-4.

The Providers maintain while the Board has jurisdiction over this group appeal, the Board does not have the power to grant the relief sought by them. They are challenging the standardized amount for FFY 2019 as published by CMS in the Federal Register; the Board does not have the authority to resolve this challenge. The Providers assert the Board has previously found itself bound by CMS' final rules and lacking authority to review the data underlying the rate published unless specifically authorized to do so. Therefore, the Providers request that the Board grant EJR.

Decision of the Board

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

Jurisdiction and Requests for EJR for Providers in Case No. 19-1574G

The Board finds that the Providers in optional group appeal Case No. 19-1574G, HRS FFY 2019 ATRA IPPS 0.7% Rate Reduction 2 Group, did not timely appeal from the FFY 2019 IPPS Final Rule, 83 Fed. Reg. 41144 (August 17, 2018), which gave rise to the dispute under appeal. Rather, the Providers filed their appeal from the *correcting* document at 83 Fed. Reg. 49836 (October 3, 2018) which made corrections to the FFY 2019 IPPS Final Rule. The Board finds that the correcting document did not make a substantive change to the reimbursement rates the Providers are challenging, nor did it make substantive changes to the policies or payment methodologies that were adopted in the Final Rule; the correcting document does not establish policy (much less the policy that is at issue here).[34] As such, the Board concludes that it does not have jurisdiction over the Providers' untimely appeal in Case No. 19-1574G from the FFY 2019 IPPS Final Rule which gave rise to the dispute. As jurisdiction is a prerequisite to EJR, the Board hereby denies the Providers' request for EJR in Case No. 19-1574G.

Jurisdiction and Requests for EJR for the ***Remaining*** Providers in Case Nos. 19-0963GC, 19-0964GC, 19-0965GC, 19-0966GC, 19-0980GC, 19-0981GC, 19-0985GC, 19-1013GC, 19-1014GC, 19-1040GC, 19-1101G, 19-1114GC, and 19-1134GC

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply with the 0.7 percent reduction to the IPPS standardized amount for FFY 2019 as published in the FFY 2019 IPPS Final Rule on August 17, 2018, because CMS clearly intended to bind all hospitals, which are

[34] To the extent the correcting document can be considered a "revised" determination under 42 C.F.R. §§ 405.1885 and 405.1887, there would be no appeal rights under § 405.1887 because the Providers' issue in this appeal was not otherwise revised in that correcting document. As such, the Board must conclude that there are no appeal rights associated with the correcting document.

subject to IPPS, to this payment reduction and, as such, it is an uncodified regulation adopted through the Federal Register rulemaking process. Accordingly, the Board concludes that it lacks the authority to grant the relief sought by the *remaining* Providers,[35] to reverse or otherwise invalidate the negative adjustment of 0.7 percent to the IPPS standardized amount for FFY 2019 as published in the FFY 2019 IPPS Final Rule. Consequently, the Board hereby grants EJR for the issue and FFY under dispute for the *remaining* Providers. Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling. In these cases, the *remaining* Providers filed timely appeals of the FFY 2019 IPPS Final Rule as published in the Federal Register on August 17, 2018[36] and the amount in controversy exceeds the $50,000 threshold for jurisdiction over each group.[37] The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount in each case.

The Board finds that:

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

2) Based upon the participants' assertions regarding the 0.7 percent reduction to the IPPS standardized amount, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the 0.7 percent reduction to the FFY 2019 IPPS standardized amount as published in the FFY 2019 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the 0.7 percent reduction to the FFY 2019 IPPS rate as published in the FFY 2019 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby finds that EJR is appropriate for the issue and

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[35] The Board notes that St. Luke's Hospital (Provider No. 36-0090, FYE 9/30/19) was included on the original Schedule of Providers filed with the CIRP group appeal request for Case No. 19-0980GC, HRS ProMedica Health System FFY 2019 ATRA IPPS 0.7% Rate Reduction CIRP Group. However, St. Luke's Hospital was ***not*** included on the final Schedule of Providers for Case No. 19-0980GC. As such, this Provider is ***not*** a participant in the CIRP group under Case No. 19-0980GC and is ***not*** a part of this EJR determination.

[36] In accordance with the Administrator's decision in *District of Columbia Hospital Association Wage Index Group Appeal*, (HCFA Adm. Dec. January 15, 1993) *Medicare & Medicaid Guide* (CCH) ¶ 41,025 (a notice published in the Federal Register is a final determination).

[37] *See* 42 C.F.R. § 405.1837.

the subject year for the *remaining* Providers. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

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Susan Turner, Esq.

FOR THE BOARD:

10/24/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Laurie Polson, Palmetto GBA
Pam VanArsdale, NGS
Justin Lattimore, Novitas Solutions
Cecile Huggins, Palmetto GBA
Lorraine Frewert, Noridian Healthcare Solutions
Judith Cummings, CGS Administrators
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Healthcare Reimbursement Services, Inc.
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National Government Services, Inc.
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MP: INA 101-AF42
P.O. Box 6474
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RE: ***Jurisdictional Determination***
Landmark Medical Center
FYE 9/30/13
Case No. 16-1809

Dear Ms. Goron and Ms. VanArsdale,

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

Background

The Provider filed a request for hearing on June 2, 2016, based on a Notice of Program Reimbursement ("NPR") dated December 9, 2015. The hearing request included two issues. One issue was added to the appeal via a request dated July 13, 2016. Subsequently, one issue was withdrawn and one issue was transferred to a group appeal. One issue remains in the appeal addressing "Whether the 'rural floor' budget neutrality adjustments as implemented by the Centers for Medicare and Medicaid Services ("CMS") violate the law's requirement of budget neutrality."

Provider's Final Position Paper

On June 6, 2019, a Notice of Hearing was issued for Case No. 16-1809 setting a due date of August 24, 2019 for the Provider's Final Position Paper ("Provider's FPP). On August 22, 2019, the Board received the Providers FPP Final Position Paper for Case No. 16-1809. As described therein, the sole remaining issue in the appeal is stated as follows:

> Whether the "rural floor" budget neutrality adjustments ("RFBNA") as implemented by the Centers for Medicare and Medicaid Services ("CMS") violate the law's requirement for budget neutrality.[1]

[1] Provider's Final Position Paper at 5.

The Provider states in *Cape Cod v. Sebelius*, the D.C. Circuit held that the Secretary's application of the RFBNA for FY 2007 and 2008 was improperly computed as a result of methodological/mathematical errors on the part of the Secretary. [2] In recognition of the decision in *Cape Cod*, the Secretary implemented a permanent 1.1 percent adjustment to the standardized amount beginning in FY 2012.[3]

The Provider asserts that the 1.1 percent increase to the 2012 standardized amount used to offset the cumulative rural floor budget neutrality adjustments for the period FY 1999 – FY 2006 was not adequate for purposes of eliminating the prior years' improper budget neutrality adjustments. The Provider further asserts that this increase failed to completely offset the impact of the duplicative rural floor budget neutrality adjustments to the standardized amounts during the period of FY 1999 – FY 2007, which has been the subject of significant prior litigation.[4]

The Provider maintains that the adjustments computed in the IPPS final rule for FY 2012 published on August 18, 2011[5] were based upon estimated as opposed to actual data. As a result, the Secretary did not use the best available data in her possession to compute the amount of the adjustment required to offset the prior years' duplicative budget neutrality adjustment. In addition, the Provider maintains that the Secretary's computation of these adjustments contained significant statistical and methodological errors. The Provider asserts that, if these errors are corrected and if the best available data were used by the Secretary, the resulting adjustment to the standardized amount would have been higher than the amounts implemented by the FY 2012 final IPPS rules. As a result, the duplicative budget neutrality adjustments that occurred during the period FY 1999 – FY 2007 remain embedded in the standardized amount, thereby improperly reducing the standardized amount for the 2012 cost reporting period.[6]

Medicare Contractor's Final Position Paper

After reviewing the Group's Final Position Paper, the Medicare Contractor states that the Board has jurisdiction over this appeal, but lacks authority to decide the legal question raised by the Provider. As such, the Medicare Contractor states that Expedited Judicial Review ("EJR") would be appropriate. Here the Board has general jurisdiction over this appeal because it appears to have been filed within the 180-day time limit for an appeal and the alleged amount in controversy exceeds the jurisdictional threshold.[7]

Additionally, the Medicare Contractor contends that the Provider points out deficiencies which it believes exist but without any evidence to support its claims. Without the data to support these contentions, the Provider's entire argument is based upon supposition. The Medicare Contractor argues that the Provider's suppositions do not prove any errors exist in the Secretary's calculations. Without evidence that the Secretary's methods were flawed and based on

[2] Provider's Final Position Paper at 12.
[3] Provider's Final Position Paper at 22.
[4] Provider's Final Position Paper at 22.
[5] 76 Fed. Reg. 51476 (Aug. 18, 2011).
[6] Provider's Final Position Paper at 22-23.
[7] Medicare Contractor's Final Position Paper at 6.

inadequate data, the Provider is not able to prove its dissatisfaction and consequently is not entitled to an appeal of errors that may not exist.[8]

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

With respect to position papers, the regulations at 42 C.F.R. § 405.1853(b)(2) state the following:

> Each position paper *must set forth the relevant facts* and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal, *and the merits* of the provider's Medicare payment claims for each remaining issue.[9]

Board Rule 27 incorporates the requirements for preliminary position papers as delineated in Board Rule 25. In this regard, it states the following, in pertinent part:

> **Rule 27 Final Position Papers**
>
> * * * *
>
> 27.2 Content
>
> The final position paper should address each remaining issue. *The minimum requirements* for the position paper narrative and exhibits *are the same as those outlined for preliminary position papers at Rule 25*.[10]

Board Rule 25 states the following in pertinent part:

> **Rule 25 Preliminary Position Papers**
>
> 25.1 Content of Position Paper Narrative
>
> The text of the position papers *must* contain the elements addressed in the following subsections.

[8] Medicare Contractor's Final Position Paper at 10.
[9] (Emphasis added.)
[10] (Italics emphasis added.)

> 25.1.1 Provider's Position Paper
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, *state the material facts that support the provider's claim*.
>
> C. *Identify the controlling authority*, (e.g. statutes, regulations, policy or, case law) *supporting the provider's position*.
>
> D. *Provide a conclusion applying the material facts to the controlling authorities*.
>
> 25.2 Position Paper Exhibits
>
> 25.2.2 Unavailable and Omitted Documents
>
> *If documents necessary to support your position are still unavailable*, identify the missing documents, *explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available*. Once the documents become available, promptly forward them to the Board and the opposing party.[11]

Finally, the regulations at 42 C.F.R. § 405.1868 state the following:

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

[11] (Italics emphasis added.)

(1) Dismiss the appeal with prejudice;

(2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or

(3) Take any other remedial action it considers appropriate.

In reviewing both the Provider's original appeal request dated June 2, 2016 and final position paper filed *over three years later* on August 22, 2019, the Board notes that the Provider's dispute centers around CMS' 1.1 percent adjustment to the standardized amount adopted in the FY 2012 IPPS Final Rule. The Provider questions the data and methodology used to calculate this 1.1 percent adjustment. However, the Provider at this late date did not include an explanation of why the data and/or methodology are flawed (*i.e.*, the merits of their claim).

The Board notes that, in the excerpt from the FY 2012 IPPS Final Rule included at Exhibit P-4, CMS states that it provided "more detail on how we calculated the one-time adjustment for purposes of determining the FY 2012 IPPS rates. All of the data files discussed in this response are available to the public for download at *http://www.cms.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage*." The Board notes that the FY 2012 IPPS Final Rule was published ***more than 8 years*** prior to the August 24, 2019 filing deadline yet the Provider's Final Position Paper does not discuss this public data file posting. Moreover, notwithstanding 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.2.2, the Provider's final position paper does not set forth ***any*** information as to:

1. Why the Provider disputes the calculation and methodology in the FY 2012 IPPS Final Rule; and

2. What factual information they need that is not in the FY 2012 IPPS Final Rule (or available for download at the link provided in that final rule) to determine if CMS' calculation is correct.

The Board finds that the Provider failed to develop its case as required by the regulations and the Board Rules. The Provider failed to develop facts and arguments regarding its dispute in its final position paper and only states that CMS' calculation was inadequate. The Provider failed to set forth the merits of its claim, explain why the agency's calculation is wrong, identify missing documents to support its claim, and explain when the documents will be available. The case has been pending at the Board since June 2016 and, without a good cause showing to the contrary, the Board concludes that the Provider has had adequate time to develop the merits of its case and prepare its arguments.[12]

[12] If the Provider needed more time to meet the position paper requirements. The Provider could have requested an extension. In the regard, the Board notes that Board Rule 23.5 permits parties to request extension on position paper filing deadlines: "Requests for extensions for filing a PJSO or preliminary position paper must be filed at least three weeks before the due date and will be granted only for good cause." However, the Provider did not request such an extension and instead made an insufficient filing. Further, the fact that the Provider later filed an EJR request

The Board finds that the Provider has essentially abandoned the appeal by filing a perfunctory position paper filing that did not include any discussion or analysis of the data files that have been available to the public since the FY 2012 IPPS Final Rule was published ***more than 8 years earlier*** in August 2011. [13] As such, the Board concludes that the Provider has violated Board Rule 25.2.2 and 42 C.F.R. 405.1853(b)(2) because the Provider's final position paper did not set forth the relevant facts and arguments regarding the merits of the Provider's claims. Therefore, the Board dismisses the appeal and removes it from the Board's docket.

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

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For the Board:

10/24/2019

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cc: Wilson C. Leong, Federal Specialized Services

roughly 2 months later on October 21, 2019 does not impact the Board finding or the Provider's obligations regarding the content of final position papers.

[13] *See supra* note 12. The Board also notes that the section in the Provider's FPP discussing why the 1.1 percent adjustment "was inadequate" is only one paragraph in length. The paragraph has 7 sentences consisting of conclusory statements devoid of support. For example, the following is four of the seven sentences and there is no citation, footnote or exhibit supporting them: "The adjustments computed in the FY 2012 final IPP rule were based upon estimated as opposed to actual data. As a result, the Secretary did not use the best available data in her possession to compute the amount of the adjustment required to offset the prior years' duplicative budget neutrality adjustment. In addition, the Secretary's computation of these adjustments contained significant statistical and methodological errors. The Provider asserts that if these errors are corrected, and if the best available data were used by the Secretary, the resulting adjustment to the standardized amount would have been higher than the amounts implemented by the FY 2012 final IPPS rules."

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Mail

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RE: ***Expedited Judicial Review Determination***
The Toledo Hospital (Provider No. 36-0068, FYE 12/31/2016)
Case No. 19-1578

Dear Mr. Ruskin:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's September 30, 2019 request for expedited judicial review ("EJR") in the above-referenced appeal. The decision with respect to EJR is set forth below.

Issue under Dispute

In this case, the Provider is:

> challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states in effect that urban hospitals may qualify for Capital DSH [disproportionate share hospital] payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. [The Provider contends that] [t]his regulation is inconsistent with [42 U.S.C. § 1395ww(d)(8)(B)] which concerns rural status. [42 U.S.C. § 1395ww(d)(8)(B)] specifically notes that the hospitals that have undergone a rural reclassification are rural only for "purposes of this subsection [1395ww(d)]."[1]

Background

A. Geographic Reclassification

Under the inpatient prospective payment system ("IPPS"), the Medicare program pays hospitals for their operating costs based on predetermined rates for patient discharges. Similarly, the Medicare program pays hospitals for their capital costs based on a capital prospective payment

[1] Provider's Request for EJR at 2.

system ("Capital PPS"). The primary objective of both IPPS and the Capital PPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[2]

In 1989, Congress created a geographic reclassification system in which IPPS hospitals can be reclassified to a higher wage index area[3] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[4]

Similarly, Capital PPS has historically had a geographic adjustment factor ("GAF"). As explained in 42 C.F.R.§ 412.316(a), the GAF adjusts for local cost variations based on the hospital wage index value that is applicable to the hospital under subpart D of this part. The adjustment factor equals the hospital wage index applicable to the hospital, raised to the 0.6848 power, and is applied to 100 percent of the Federal rate.

B. Disproportionate Share Hospital ("DSH") Adjustment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under IPPS.[5] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[6]

The IPPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[7] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[8]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[9] As a proxy for utilization by low-income patients, the DPP determines a hospital's

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[2] Dep't of Health & Human Servs., Ofc. of the Inspector Gen., OIG Rept. No. A-01-17-00500, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments* at 1 (Nov. 2018) (available at: https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Oct. 17, 2019)) ("*Significant Vulnerabilities*").
[3] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html. 42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with §§ 1395ww(d)(8)(B) and 1395ww(d)(10).
[4] *Significant Vulnerabilities* at 5.
[5] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[6] *Id.*
[7] *See* 42 U.S.C. § 1395ww(d)(5).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).

qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[10]

Similar to IPPS, the Medicare program includes a DSH adjustment for Capital PPS. Specifically, Capital DSH only applies to urban hospitals with 100 or more beds and that serve low income patients.[11]

In the IPPS proposed rule for FY 2007, the Secretary[12] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the Capital DSH adjustment.[13] The Secretary characterized these proposed changes as reflecting CMS' historic policy that hospitals reclassified as rural under § 412.103 for IPPS purposes also would be considered rural under the Capital PPS. Since the genesis of the Capital PPS in FY 1992, the same geographic classifications used under the IPPS (which encompasses a provider's operating costs) also have been used under the Capital PPS.[14]

The Secretary asserted that these proposed changes and clarifications were necessary because the agency's Capital PPS regulations had been updated to incorporate the Office of Management and Budget's ("OMB's") new Core Based Statistical Area ("CBSA") definitions for the IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule,[15] in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, the Secretary revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the Capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, 412.320(a)(1)(iii) states that the geographic classifications specified under § 412.64 applied, *other than* discharges occurring on or after October 1, 2006 from an urban hospital that is reclassified as rural pursuant to 412.103, in which case the hospital's geographic classification is rural.

The Secretary asserted that this error must be corrected in order to maintain the agency's historic policy for treating urban-to-rural hospital reclassifications under IPPS the same for purposes of the Capital PPS.[16] Therefore, the Secretary proposed to specify under §§ 412.316(b)(2) and (b)(3) and §§ 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[17] The Secretary finalized these changes in the August 18, 2007 Final IPPS Rule.[18]

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[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[11] MedPAC, Hospital Acute Inpatient Services Payment System: Payment Basics at 4 (rev. Oct. 2016) (available at: http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_hospital_final.pdf (last visited Oct. 30, 2019)).
[12] Secretary of the Department of Health and Human Services.
[13] 71 Fed Reg. 47870, 48104 (Aug. 18, 2006).
[14] *Id.*
[15] 69 Fed. Reg. 48916, 49187-48188 (Aug. 11, 2004).
[16] 71 Fed. Reg. 23996, 24122 (Apr. 25, 2006).
[17] *Id.*
[18] 71 Fed. Reg. 47870, 48104 (Aug. 18, 2006).

The regulation, 42 C.F.R. § 412.320(a)(1)(iii), as codified states:

> (a) Criteria for classification. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> (iii) *For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.*

Provider's Request for EJR

The Provider states that EJR is appropriate for the appeal of its December 31, 2016 cost report because it is challenging the regulation that governs the status of urban hospitals that have been reclassified under 42 U.S.C. § 1395ww(d)(8)(B) and 42 C.F.R. § 412.103 (hospitals located in urban areas and that apply for reclassification as rural). More specifically, the Provider is contesting the application of 42 C.F.R. § 412.320(a)(1)(iii), which states, in effect, that urban hospitals may qualify for Capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Provider asserts that this regulation is inconsistent with 42 U.S.C. § 1395ww(d)(8)(B) which states that hospitals that have undergone a rural reclassification are rural only for "purposes of this subsection [1395ww(d)(8)(B)]." The Capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the Capital DSH calculation. The Provider maintains that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. § 1395ww(d)(8)(B), and the regulation must be found invalid.

The Provider points out that the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have be reclassified as rural to payment provisions outside of § 1395ww(d). For example, with respect to direct graduate medical education ("DGME"), the

Secretary has stated that no adjustments to the DGME cap were available for urban hospitals that have reclassified as rural because § 1395ww(d) reclassifications "affect only the payments that are made under section [1395ww(d)]."[19] The Provider contends that this position is incompatible with the use of acquired rural status to remove Capital DSH payments under 42 C.F.R. § 412.320(a)(1)(iii). The Provider argues that the Secretary should be consistent: either there should be no Capital DSH reduction, or providers with acquired rural status should have favorable DGME status. Since the Board is bound by the regulations[20] and lacks the authority to decide the legal question—a challenge to the validity of 42 C.F.R. § 412.320(a)(1)(iii) – the Provider believes EJR is appropriate.

Decision

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

A. Compliance with requirements for filing a Board appeal

The Board has determined that, in the instant appeal and associated EJR request, the Provider's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an appeal[21] and the appeal was timely filed.[22] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873

The Provider appealed the NPR covering the cost reporting period ending December 31, 2016 and is subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[23] Specifically, effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an appropriate claim on its cost report by either claiming the item in accordance

[19] 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005).
[20] *See* 42 C.F.R. § 405.1867.
[21] *See* 42 C.F.R. § 405.1835(a)(2).
[22] *See* 42 C.F.R. § 405.1835(a)(d).
[23] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").

with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[24]

The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[25] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[26] As no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[27] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made.[28] As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board's Analysis Regarding the Appealed Issue

The Provider in this case is challenging the application of 42 C.F.R. § 412.320(a)(1)(iii), which states in effect that urban hospitals may qualify for Capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Provider contends that this regulation is inconsistent with the enabling statute, 42 U.S.C. § 1395ww(d)(8)(B), which concerns rural status. The Provider contends that §1395ww(d)(8)(B) specifically notes that the hospitals that have undergone a rural reclassification are rural only for "purposes of this

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[24] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[25] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[26] *See* 42 C.F.R. § 405.1873(a).
[27] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[28] Although no question was raised in this appeal regarding whether an appropriate claim was made, the Board recognizes that the Provider's cost report included a claim for the disputed Capital DSH payment as a protested amount on its as-filed cost report as evidenced by Tab 4.B of the Provider's February 22, 2019 hearing request which includes the protest support for the Capital DSH issue. In addition, the audit adjustment report that accompanied the Provider's Notice of Program Reimbursement included Audit Adjustment No. 26 which stated that it was utilized:

> To remove protested amounts related to the disallowance of capital DSH payments subsequent to the effective date of the Rural Reclassification.

Audit Adjustment No. 26 was identified as the subject of this appeal on the Board's Model Form A which requires the identification of issues under appeal and the related audit adjustment.

subsection [1395ww(d)]." Additionally, the Provider asserts that the Capital DSH provisions are found at 42 U.S.C. § 1395ww(g), not § 1395ww(d), and, accordingly, the literal wording of the rural reclassification statutory provision identifies that rural status does not reach the Capital DSH calculation. The Provider maintains that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. § 1395ww(d)(8)(B), and the regulation must be found invalid.

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply all the provisions of Title XVIII of the Act and regulations issued thereunder, including the challenged regulation, 42 C.F.R. § 412.320(a)(1)(iii). Moreover, pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Accordingly, the Board concludes that it lacks the authority to grant the relief sought by the Providers, *i.e.*, to reverse or otherwise invalidate 42 C.F.R. § 412.320(a)(1)(iii). Consequently, the Board hereby grants the Provider's request for EJR for the issue and federal fiscal year under dispute.

D. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) No party to the appeal has questioned pursuant to § 405.1873(a) whether an appropriate claim was made and, as a consequence, the Board has no regulatory obligation to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made under 42 C.F.R. § 413.24(j);

3) Based upon the participant's assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.320(a)(1)(iii) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of

this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

10/30/2019

X Clayton J. Nix

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

cc: Judith Cummings, CGS Administrators
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Mail

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RE: ***EJR Determination***
Banner Health 2013 & 2015 DGME Fellowship Penalty Group
Case No. 18-1334GC

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' September 30, 2019 request for expedited judicial review ("EJR") (received October 1, 2019). The decision of the Board is set forth below.

The issue for which EJR is requested is:

> . . .the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Providers assert that] the regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the statute because it determines the cap after application of weighting factors.[1]

Background

The Medicare statute requires the Secretary[2] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME"). [3] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[4]

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

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[1] Providers' EJR request at 1.
[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395ww(h).
[4] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[5]

This appeal concerns the first component of the DGME payment calculation—the resident FTE count.

The Medicare Statute

A hospital's FTE count for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[6] ("*IRP residents*") are weighted at 100 percent or 1.0 while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "*fellows*") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[7] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

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[5] 42 U.S.C. § 1395(h).
[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[9] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> •*Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology

[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and***

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[12]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[13] This regulation is the focus of these appeals and this EJR request, and it states the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

As previously noted, this regulation addresses how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility that year.[15]

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[12] *Id.* at 39894 (emphasis added).
[13] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that were in the prior version of the regulation and replacing them with reference to "the limit described in this section."
[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[16]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, is averaged with the FTE counts from the prior and penultimate years.

The Providers' Position

The Providers assert that the MAC's calculations of the current, prior-year and penultimate-year DGME FTES and the FTE caps are contrary to the statutory provisions at 42 U.S.C. § 1395ww(h), and, as a result , the Providers' DGME payments are understated. The Providers contend that the regulation implementing the cap and the weighting factors is contrary to the statute because it determines the cap after the application of the weighting factors.[17] The effect of this regulation is to impose on the Providers weighting factors that result in reductions greater than 0.5 for many residents who are beyond the IRP, and the regulation prevents the Providers from claiming and receiving reimbursement for their full unweighted FTE caps.[18]

The Providers explain that the Medicare statute caps the number of residents that a hospital can claim at the number it trained in cost years ending in 1996.[19] The statute states that, for residents beyond the IRP, "the weighting factor is .50."[20] The statute also states that the current year FTEs are capped before application of the weighting factors: "the total number of full-time equivalent residents before application of the weighting factors . . . may not exceed the number . . . of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996."[21] The Providers conclude that this statutory scheme sets an absolute weighting factor on fellows of 0.5 and requires that the weighting factors are not applied when capping the current year FTEs.

The Providers claim that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[22]

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[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[18] 42 C.F.R. § 413.79(c)(2).
[19] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[20] *Id.* at § 1395ww(h)(4)(C)(iv).
[21] *Id.* at 1395ww(h)(4)(F)(i).
[22] 42 U.S.C. § 1395ww(h)(4)(F)(i).

Instead, a weighted FTE cap is determined for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE(UCAP/UFTE) = WCap,[23] is applied to the weighted FTE count in the current year which creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Providers contend that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[24]

Second, the Providers posit, the weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The Providers explain that the downward impact on the FTE count increases as hospital trains more residents beyond the IRP and the problem increase as a hospital trains more fellows because the methodology amplifies the reduction.

Third, in some situations, as demonstrated by the Table on page 12 of the Providers' EJR request, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Providers point out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.

The Providers conclude that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion. Since, the Board lacks the authority to grant the relief sought, the request for EJR should be granted.

Decision of the Board

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

A. Background on Appeals of Self-Disallowed Costs

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

[23] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[24] *Id*. at §1395(h)(4)(F)(i).

Bowen ("*Bethesda*").[25] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[26]

On August 21, 2008, new regulations governing the Board were effective.[27] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*") before the D.C. District Court.[28] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The D.C. District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[29]

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

B. Board Jurisdiction

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R since they are challenging a regulations as described more fully below. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[30] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and

[25] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[26] *Bethesda*, 108 S. Ct. at 1258-59.
[27] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[28] 201 F. Supp. 3d 131 (D.D.C. 2016).
[29] *Id.* at 142.
[30] *See* 42 C.F.R. § 405.1837.

the underlying participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

C. Board's Analysis of the Appealed Issue

The Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between residents in their initial training period and fellows. The Providers assert that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this formula results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Providers present the following equation in their request for EJR used to calculate the allowable count for primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}$$ [31]

Accordingly, the Board set out to confirm the Providers' assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[32] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[33] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the Providers that § 413.79(c)(2)(iii) essentially states the above equation, albeit in a slightly

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[31] EJR Request at 4.
[32] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[33] 66 Fed. Reg. at 39894 (emphasis added).

different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) states:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[34]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[35] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[36] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[37] (*i.e.*, ratios) using variables a, b, c, and d:

$$If\ \frac{a}{b} = \frac{c}{d}\ \ then\ \ c = \frac{a}{b}\ x\ d$$

On the first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***)

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[34] (Emphasis added.)
[35] *See* 62 Fed. Reg. at 46005 (emphasis added).
[36] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).
[37] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[38]

On the other side of the algebraic equation (*i.e.*, the ratio of "c / d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same proportion." This phrase expressed as a ratio ("c/d") is an *unknown* Weighted FTE Cap over the FY's Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

$$\frac{Weighted\ FTE\ Cap\ (c)}{FY's\ Weighted\ FTE\ Count\ (d)} = \frac{Unweighted\ \ FTE\ Cap\ (a)}{FY's\ Unweighted\ FTE\ Count\ (b)}$$

The unknown Weighted FTE Cap (variable "c") is then determined by a/b x d. In other words, the unknown Weighted FTE Cap is determined by the following formula:

$$\boldsymbol{Weighted\ FTE\ cap} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times\ Weighted\ FTE\ Count$$

This formula is clearly stated in the preambles to both the FYs 1998 and 2002 IPPS Final Rules as previously quoted.

Based on the above, the Board finds that 42 C.F.R. § 413.79(c)(2)(iii) does set forth the equation being challenged and, accordingly, that the Providers are challenging the validity of § 413.79(c)(2)(iii). Since 42 C.F.R. § 405.1867 requires that the Board comply with the requirements of the statute and regulations, the Board lacks the authority to eliminate the regulatory provision that creates the alleged penalty in § 413.79(c)(2)(iii) which is the remedy the Providers are seeking. Consequently, EJR is appropriate for the issue under dispute in these cases.

Board's Decision Regarding the EJR Request

The Board finds that:

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

[38] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

2) Based upon the participants' assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

10/31/2019

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: John Bloom, Noridian Healthcare Solutions
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Mail

Ronald S. Connelly, Esq.
Powers, Pyles, Sutter & Verville
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Washington, D.C. 20005

RE: ***EJR Determination***
Powers Pyles 2015 GME Solutions DGME Fellowship Penalty Group
Case No. 18-1739GC

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' October 1, 2019 request for expedited judicial review ("EJR") (received October 2, 2019). The decision of the Board is set forth below.

The issue for which EJR is requested is:

> . . .the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Providers assert that] the regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the statute because it determines the cap after application of weighting factors.[1]

Background

The Medicare statute requires the Secretary[2] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME"). [3] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[4]

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

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[1] Providers' EJR request at 1.
[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395ww(h).
[4] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[5]

This appeal concerns the first component of the DGME payment calculation—the resident FTE count.

The Medicare Statute

A hospital's FTE count for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[6] ("*IRP residents*") are weighted at 100 percent or 1.0 while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "*fellows*") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[7] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

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[5] 42 U.S.C. § 1395(h).
[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[9] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> •*Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology

[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and***

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[12]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[13] This regulation is the focus of these appeals and this EJR request, and it states the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

As previously noted, this regulation addresses how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility that year.[15]

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[12] *Id.* at 39894 (emphasis added).
[13] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that were in the prior version of the regulation and replacing them with reference to "the limit described in this section."
[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[16]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, is averaged with the FTE counts from the prior and penultimate years.

The Providers' Position

The Providers assert that the MAC's calculations of the current, prior-year and penultimate-year DGME FTES and the FTE caps are contrary to the statutory provisions at 42 U.S.C. § 1395ww(h), and, as a result , the Providers' DGME payments are understated. The Providers contend that the regulation implementing the cap and the weighting factors is contrary to the statute because it determines the cap after the application of the weighting factors.[17] The effect of this regulation is to impose on the Providers weighting factors that result in reductions greater than 0.5 for many residents who are beyond the IRP, and the regulation prevents the Providers from claiming and receiving reimbursement for their full unweighted FTE caps.[18]

The Providers explain that the Medicare statute caps the number of residents that a hospital can claim at the number it trained in cost years ending in 1996.[19] The statute states that, for residents beyond the IRP, "the weighting factor is .50."[20] The statute also states that the current year FTEs are capped before application of the weighting factors: "the total number of full-time equivalent residents before application of the weighting factors . . . may not exceed the number . . . of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996."[21] The Providers conclude that this statutory scheme sets an absolute weighting factor on fellows of 0.5 and requires that the weighting factors are not applied when capping the current year FTEs.

The Providers claim that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[22]

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[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[18] 42 C.F.R. § 413.79(c)(2).
[19] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[20] *Id.* at § 1395ww(h)(4)(C)(iv).
[21] *Id.* at 1395ww(h)(4)(F)(i).
[22] 42 U.S.C. § 1395ww(h)(4)(F)(i).

Instead, a weighted FTE cap is determined for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE(UCAP/UFTE) = WCap,[23] is applied to the weighted FTE count in the current year which creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Providers contend that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[24]

Second, the Providers posit, the weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The Providers explain that the downward impact on the FTE count increases as hospital trains more residents beyond the IRP and the problem increase as a hospital trains more fellows because the methodology amplifies the reduction.

Third, in some situations, as demonstrated by the Table on page 12 of the Providers' EJR request, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Providers point out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.

The Providers conclude that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion. Since, the Board lacks the authority to grant the relief sought, the request for EJR should be granted.

Decision of the Board

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

A. Background on Appeals of Self-Disallowed Costs

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

[23] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[24] *Id*. at §1395(h)(4)(F)(i).

Bowen ("*Bethesda*").[25] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[26]

On August 21, 2008, new regulations governing the Board were effective.[27] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*") before the D.C. District Court.[28] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The D.C. District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[29]

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

B. Board Jurisdiction

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R since they are challenging a regulations as described more fully below. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[30] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and

[25] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[26] *Bethesda*, 108 S. Ct. at 1258-59.
[27] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[28] 201 F. Supp. 3d 131 (D.D.C. 2016).
[29] *Id.* at 142.
[30] *See* 42 C.F.R. § 405.1837.

the underlying participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

C. Board's Analysis of the Appealed Issue

The Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between residents in their initial training period and fellows. The Providers assert that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this formula results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Providers present the following equation in their request for EJR used to calculate the allowable count for primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}$$ [31]

Accordingly, the Board set out to confirm the Providers' assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[32] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[33] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the Providers that § 413.79(c)(2)(iii) essentially states the above equation, albeit in a slightly

[31] EJR Request at 4.
[32] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[33] 66 Fed. Reg. at 39894 (emphasis added).

different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) states:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[34]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[35] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[36] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[37] (*i.e.*, ratios) using variables a, b, c, and d:

$$If\ \frac{a}{b} = \frac{c}{d}\ \ then\ \ c = \frac{a}{b}\ x\ d$$

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***)

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[34] (Emphasis added.)
[35] *See* 62 Fed. Reg. at 46005 (emphasis added).
[36] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).
[37] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[38]

On the other side of the algebraic equation (*i.e.*, the ratio of "c / d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same proportion." This phrase expressed as a ratio ("c/d") is an *unknown* Weighted FTE Cap over the FY's Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

$$\frac{Weighted\ FTE\ Cap\ (c)}{FY's\ Weighted\ FTE\ Count\ (d)} = \frac{Unweighted\ \ FTE\ Cap\ (a)}{FY's\ Unweighted\ FTE\ Count\ (b)}$$

The unknown Weighted FTE Cap (variable "c") is then determined by a/b x d. In other words, the unknown Weighted FTE Cap is determined by the following formula:

$$\boldsymbol{Weighted\ FTE\ cap} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times\ Weighted\ FTE\ Count$$

This formula is clearly stated in the preambles to both the FYs 1998 and 2002 IPPS Final Rules as previously quoted.

Based on the above, the Board finds that 42 C.F.R. § 413.79(c)(2)(iii) does set forth the equation being challenged and, accordingly, that the Providers are challenging the validity of § 413.79(c)(2)(iii). Since 42 C.F.R. § 405.1867 requires that the Board comply with the requirements of the statute and regulations, the Board lacks the authority to eliminate the regulatory provision that creates the alleged penalty in § 413.79(c)(2)(iii) which is the remedy the Providers are seeking. Consequently, EJR is appropriate for the issue under dispute in these cases.

Board's Decision Regarding the EJR Request

The Board finds that:

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

[38] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

2) Based upon the participants' assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

10/31/2019

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Byron Lamprecht, WPS Government Health Administrators
Wilson Leong, FSS