DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Jurisdictional Determination***
Hollywood Presbyterian Medical Center (05-0063) FYE 12/31/2014, Case No. 21-0233

Dear Ms. Ellis and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Representative's December 9, 2020 requests for transfer of the two issues in the subject appeal to optional groups. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

Toyon Associates, Inc. ("Toyon") filed a Reopening Request for the Provider on December 10, 2019 styled as a reopening for "SSI Ration Realignment." In its request, Toyon indicates that, "pursuant to 42 CFR 412.106(b)(3)" the provider is requesting ". . . a recalculation of its SSI ratio *based on its cost reporting period rather than the federal fiscal year*."[1]

The MAC issued a Notice of Reopening, on December 18, 2019, in which it advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio."

The Notice of Amount of Corrected Reimbursement (RNPR) was issued on June 1, 2020.[2]

Toyon filed an individual appeal for the Provider on November 18, 2020, to which the Board assigned Case No. 21-0233. The two issues in the appeal are:

DSH Accuracy of CMS Developed SSI Ratio
DSH Inclusion of Medicare Part C Days in the SSI Ratio

[1] (Emphasis added.)
[2] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").

Toyon referenced Audit Adjustment # 4 for both issues. This Audit Adjustment was made "[t]o include the SSI Percentage as calculated by CMS at the request of the provider and to amend the allowable DSH Percentage." Following realignment, the SSI percentage increased from 49.78 to 50.87 and the DSH was adjusted from 75.68 to 76.58.

On December 9, 2020, Toyon requested the transfer of *both* issues to optional group cases: the SSI Accuracy issue to Case No. 21-0342G and the SSI Ratio Part C Days issue to Case No. 21-0343G.[3]

Board Determination

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

Relevant Regulations – RNPRs

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

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

Additionally, 42 C.F.R. § 405.1889 (2018)[4] explains the effect of a cost report revision:

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

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[3] The Provider, Hollywood Presbyterian Medical Center, is one of two participants used to form the **optional** groups. The other participant in both groups, Community Hospital of Monterey Peninsula (05-0145) also appealed from a Realignment RNPR and transferred the issue from individual appeal, Case No. 20-1636. The individual appeal for Community Hospital of Monterey Peninsula (05-0145) has since been closed upon transfer of the only two issues to groups.

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

> or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination.* A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[5]

The Board finds that it does not have jurisdiction over the SSI Accuracy and SSI Fr. Part C Days issues in this individual appeal because the Provider does not have appeal rights under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1) to appeal these issues from RNPR at issue.

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[5] (Emphasis added.)

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[6] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. The Audit Adjustment No. 4 associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. More specifically, the determinations were only being reopened to include the realigned SSI percentages where the SSI percentages were realigned from the federal fiscal year to the provider's respective fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment (and, as a result, none of the underlying data changes, including any Part C days included in the month-by-month data).[7] In other words, the determinations were only being reopened to include the realigned SSI percentages and CMS' realignement process (as described in the Federal Register) does ***not*** entail re-running of the data matching process that the Provider is trying to appeal.[8] Since the only matters specifically revised in the revised NPRs were adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, the Board does not have jurisdiction over the two issues in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[9]

In conclusion, the Board dismisses the SSI Accuracy and SSI Fr. Part C Days issues from Case No. 21-0233 as the Provider does not have the right to appeal the RNPR at issue under 42 C.F.R. § 405.1889. Further, the Board denies the Provider's transfer requests to Case Nos. 21-0342G and 21-0343G.

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[6] 42 C.F.R. § 405.1889(b)(1).

[7] 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). However, CMS does not utilize the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[8] *See supra* note 5.

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

As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 21-0233 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.

The Parties will receive further correspondence regarding the optional group cases (Case Nos. 21-0342G and 21-0343G) under separate cover.

Board Members Participating:

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

FOR THE BOARD:

3/2/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dylan Chinea, Toyon Associates, Inc.

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RE: ***Jurisdictional Decision - Dismissal***
Marion General Hospital (Prov. No. 36-0011)
FYE 6/30/2012
Case No. 15-0758

Dear Mr. Flynn and Ms. Cummings,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the jurisdictional documentation in Case No. 15-0758. As explained below, the Board hereby determines it lacks jurisdiction over the appeal. Accordingly, Case No. 15-0758 is now closed.

Background:

The Provider Reimbursement Review Board (the "Board") received the Provider's Request for Hearing dated December 15, 2014, related to an NPR dated June 18, 2014.[1] The Provider's Request for Hearing included two issues:

1. *Adjustment # 22 – Use of Provider's Cost Report Year for Calculation of DSH percentage (SSI Realignment)*

   Statement of the Issue: Is the Provider entitled to use data from its July 1, 2011-June 30, 2012 fiscal year for purposes of it DSH percentage calculation.

2. *Adjustment # N/A - Effect of prior year adjustments.*[2]
   "(1) Effect of Prior Year Adjustment(s) –

   Statement of the Issue: The resolution of issues raised by the provider on appeal regarding adjustments made in previous years is reasonably believed to affect the amount of program reimbursement that the provider should receive in this appealed year.

[1] Provider's Request for Appeal (Dec. 15, 2014), PRRB Case No. 15-0758.
[2] *Id.*, at Tab 3, Issue Statement.

> Brief Description of Issue: The provider believes that the resolution of all issues currently pending on appeal from prior years is necessary in order to determine whether the adjustments, in the current year, made by the [Medicare Contractor] are correct. The resolution of certain issues is reasonably believed to have a 'flow-through' effect that influences adjustments made by the [Medicare Contractor] in subsequent years such as this one.
>
> Amount in Controversy: Provider reasonably believes amount to be in excess of the $10,000 threshold for appeals. However, the provider is not able to specifically calculate the amount in controversy because the amount in controversy will be dependent upon the resolution of appeals currently pending from NPRs issued in earlier years.
>
> Legal Basis for Appeal: The provider is entitled to be correctly and completely reimbursed for its costs and services as permitted under the Medicare program. The provider is also entitled to invoke the authority of the Board, pursuant to 42 C.F.R. § 405.1869. To the extent it is necessary or required, the provider believes it can perfect an appeal to the Board to ensure the provider is completely and accurately reimbursed based on all available information, including adjustments, administrative resolutions, successful appeals or other determinations made in a prior year that has an effect on the provider's current year."

The Board initiated its own review of jurisdiction, determining whether the Board has jurisdiction over the issues. The review centers on whether the Provider's appeal issues for the SSI Realignment and "effect from prior year adjustments" are in compliance with Medicare regulations and Board Rules.

Board's Analysis and Decision

A. SSI Realignment

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

The Board finds that it does not have jurisdiction over the Medicare DSH – SSI Ratio, Realignment 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 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 Medicare DSH – SSI Ratio, Accurate Data issue in Case No. 14-364GC3 to which the Provider was directly added to on December 15, 2014.

The DSH – SSI Ratio, Realignment issue in the present appeal concerns how the SSI percentage was generated by the Social Security Administration (SSA). The Provider asserts that "the SSI percentage as generated by the [SSA] and put forth by CMS is understated" pursuant to 42 U.S.C. § 1395ww(d)(5)(F). Since the Provider is required to use the SSI percentage assigned by CMS rather than using an internally generated SSI percentage, the Provider contends that it "validly self-disallowed such an internally generated percentage in favor of that promulgated by CMS."[3]

The Provider's DSH – SSI Ratio, Accurate Data issue in group Case No. 14-3643GC also alleged that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage due to a number of factors. The Provider further contends that the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the Medicare DSH – SSI Ratio, Realignment issue in this appeal is duplicative of the Medicare DSH – SSI Ratio, Accurate Data issue in Case No. 14-3643GC.[4] 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 this issue is the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. The Provider preserving its right to request realignment of the SSI should be dismissed by the Board due to 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 appeal. Without a final determination, the dissatisfaction requirement cannot be met for the Board to have jurisdiction. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the dissatisfaction requirement is not met and the Board dismisses this issue due to a lack of jurisdiction.

Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to

[3] "Sutter Tracy Community Hospital, Statement of Appeal Issues," at 2 (April 27, 2015).
[4] The Provider representative withdrew group appeal under Case No. 14-3643GC on January 23, 2020. This does not make the Provider's participation in this group any less of a duplicate since it was not withdrawn due to that duplication. Indeed, this withdrawal only provides an alternate basis to dismiss this issue.

use its own cost reporting period is the hospital's alone, which then must submit a written request to the Medicare Contractor. Without this request it is not possible for the Medicare Contractor to have issued a final determination from which the Provider could appeal.

It is also noted that the record reflects that on February 11, 2015, the MAC issued a Notice of Intent to Reopen Cost Report, concerning the SSI Realignment Issue (Issue 1), under appeal. In the Notice, the MAC noted that:

> We are hereby reopening your cost report for the following reason:
>
> To update the SSI percentage based on the hospital's fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 2/03/2015."[5]

It is unclear as to if a revised Notice of Program Reimbursement was issued pursuant to that Notice of Reopening, and if it had, the Provider should have also withdrawn the issue from the appeal, as resolved.

B. Effect of Prior Year Adjustments

A provider is entitled to a hearing before the Board if (1) such provider is dissatisfied with a final determination of the Medicare Contractor as to its amount of total program reimbursement due the provider; (2) the amount in controversy is $10,000 or more; and, (3) such provider files a request for a hearing within 180 days after notice of the final determination.[6] The related regulations and Board rules describe in more detail what is required in order to file a hearing request with the Board. 42 C.F.R. § 405.1835(a) addresses a provider's right to Board hearing as follow, in pertinent part:

> (a) *Right to hearing on final contractor determination*. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for **specific** items claimed for a cost reporting period covered by a final contractor or Secretary determination if—
>
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment **for the <u>specific</u> item(s) at issue**, by either—
>
> (i) Including a claim **for 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

[5] MAC's Notice of Intent to Reopen Cost Report (Feb. 11, 2015).
[6] 42 U.S.C. § 1395oo(a).

> (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 (for example, if the contractor lacks discretion to award the reimbursement the provider seeks for the item(s)). [7]

42 C.F.R. § 405.1835(b) addresses the contents of a request for Board hearing and states in pertinent part:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request **must include** the elements described in paragraphs (b)(1) through (b)(4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the contractor's or Secretary's determination under appeal.
>
> (2) An explanation (for **each** **specific** item at issue, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for **each** disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for **each** disputed item.

[7] (Emphasis added.)

> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.

Board Rule 7 (Mar. 1, 2013) states: "For each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction." Board Rule 7.1(A) requires a concise issue statement describing the adjustment, including the adjustment number; why the adjustment is incorrect; and, how the payment should be determined differently.[8] Alternatively, if the Provider does not have access to the underlying information, it must describe why that information is not available.[9] These requirements are reiterated in Model Form A, the Individual Appeal Request form, which was utilized by the Provider to file its appeal.[10] Model Form A provides that:

> The statement of the issue(s) must conform to the requirements of the regulations found at 42 C.F.R. § 405.1835 et seq. and the Board's Rules and must include: (1) a description of the issue; (2) the audit adjustment number(s), if applicable, or other evidence required by 42 C.F.R. § 405.1835 (a)(1)(ii); (3) the amount in controversy; and (4) a statement identifying the legal basis for the appeal (with citation to statutes, regulations and/or manual provisions).[11]

The Provider did not appeal a *specific* issue, but rather a "flow-through effect" from any prior appeals. The Board recognizes that, in the appeal request, the Provider asserts that it does not have access to the information necessary to more specifically describe the MAC's adjustments because future events, such as certain resolutions and potential re-openings, could affect such underlying data. However, the stated issue is too nebulous and ambiguous. The Provider did not cite to any audit adjustments, protested items (*see* 42 C.F.R. § 405.1835(a)(1)(ii)), describe what "flow-through effects" it was referring to (*e.g.*, GME prior year or penultimate year), or specify which determination(s)/issue(s) from other appeals it was referring to. The Provider still must identify which "flow through" effects it is appealing.[12] Finally, it is clear that, notwithstanding the directive in 42 C.F.R. § 405.1835(a)(1)(ii), the Provider failed to protest the "flow through" issue with associated supporting documentation as described in the Provider Reimbursement Manual, CMS Pub. 15-2, § 115. Thus, the Board is unable to determine what issue is in dispute. Therefore, the Board finds that Marion's appeal lacks specificity as required by § 405.1835(b) and Board Rule 7.1(A).

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[8] *Id.* at 7.1A.
[9] *Id.* at 7.1B.
[10] *See* Model Form A, PRRB Board Rules, at 48-51.
[11] *Id.* at 50. (Section 8 of Model Form A describes the requirements for appealed issues).
[12] In its initial appeal request, the provider states: "[t]o the extent it is necessary or required, the provider believes it can perfect an appeal to the Board to ensure the provider is completely and accurately reimbursed…" The Provider in no way "perfects" or specifically clarifies any issues and does not make any claims that permit the Board to make a determination in this case.

In summary, the Board dismisses Issues 1 and 2 in their entirety based on the findings that Issue 1 is duplicative, in part, and premature, in the remaining part, and that Issue 2 lacks the requisite specificity to be a valid appeal. As such, there are no more issues remaining in the appeal, and the Board hereby closes the case and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

3/3/2021

X Clayton J. Nix

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

cc: Edward Lau, Esq., Federal Specialized Services
Wilson Leong, Federal Specialized Services

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RE: ***Jurisdictional Challenge***
Stanford Health Care (Prov. No. 05-0441)
FYE 08/31/2008
Case No. 20-0616

Dear Ms. Ellis and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal and finds that it does not have jurisdiction over the following two issues: (10 Medicare Disproportionate Share Hospital ("DSH") Payments – Accuracy of CMS Developed SSI Ratio; and (2) Medicare DSH Payments – Inclusion of Medicare Part C Days in the SSI Ratio. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

After the Provider was issued an *original* Notice of Program Reimbursement ("NPR"), the Provider requested a recalculation of the Medicare SSI percentage based upon the its cost report period in accordance with 42 C.F.R. § 405.106(b)(3). The Provider made this request on October 26, 2018. The Medicare Contractor agreed to reopen the cost reports once a response was received from CMS to realign the SSI ration based on the Provider's fiscal year and issued a Notice of Reopening. The SSI adjustment identified as the subject of the dispute in this case reflect implementation of the SSI ratio realigned by CMS and adjusted by the Medicare Contractor.

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."

On August 1, 2019, the Provider was issued a revised Notice of Program Reimbursement ("RNPR") to implement the Realigned SSI ratio pursuant to their individual requests. The disputed RNPR only adjusted the SSI percentage to the realigned ratio (from the Federal Fiscal Year to the Provider's cost report year).

The Provider then appealed the following two issues from the RNPR:

> **Issue 1: Medicare Disproportionate Share Hospital (DSH) Payments – Accuracy of CMS Developed SSI Ratio**
>
> For this issue, the Provider disputed the SSI Ratio generated by CMS and used by the Medicare Contractor in calculating the Medicare DSH payment. The Provider found that "[t]he SSI ratio is understated due to flaws and inaccuracies in CMS's match process of Medicare patient records with Social Security Administration records."[1]
>
> **Issue 2: Medicare DSH Payments – Inclusion of Medicare Part C Days in the SSI Ratio**
>
> For Issue 2, the Provider contends that "CMS' new interpretation of including Medicare Part C Days in the SSI ratio issued is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the *Northeast Hospital* decision."[2]

On January 18, 2021, the Provider requested to transfer the two issues in this individual appeal to fully formed group appeals, Case No. 18-0532G and 18-0533G.

Medicare Contractor Jurisdictional Challenge

On January 13, 2021, the Medicare Contractor filed a jurisdictional challenge over the DSH Payments – Accuracy of CMS Developed SSI Ratio and the DSH Payments – Inclusion of Medicare Part C Days issues. The Medicare Contractor alleged that the "specific issues in dispute [by the Provider] were not adjusted for the RNPR," and that the issues were duplicative of one of the Provider's appeals in a group case.

Provider's Response to Jurisdictional Challenge

On February 10, 2021, the Provider filed a response to the Medicare Contractor's jurisdictional challenge. The Provider alleges that the issues it is appealing were adjusted in the "underlying SSI ratio data" which was used in calculating the revised reimbursement amount. Provider further agrees to consolidate the RNPR and the original NPR issues in response to the Medicare Contractor's challenge on the grounds of duplicative appeals.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if

[1] Request for Hearing at 1 (January 13, 2020).
[2] *Id*.

it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that the Provider does not have the right to appeal either the DSH Part C Days or the DSH – SSI Ratio Accuracy issues from the RNPR because the specific items the Provider contested were not adjusted as part of the RNPR being appealed.

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

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

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not ***specifically revised*** (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.[3]

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

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

[3] (Emphasis added.)

> appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[4]

These regulations make it clear that the provider may only appeal items from an RNPR that are "specifically revised" in that RNPR.

The reopening for the Provider was issued as a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to the individual cost reporting fiscal year end. However, the Provider is not challenging the realignment process but rather other issues, namely the data matching process and the inclusion of Part C Days in the SSI fraction. The audit adjustment associated with the revised NPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's fiscal year. More specifically, the determination was being reopened to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the provider fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[5] In other words, the determination was only being

[4] (Emphasis added.)

[5] 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). However, CMS does not utilize the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction

reopened to include the realigned SSI percentage and CMS' realignment process (as described in the Federal Register) does ***not*** entail re-running of the data matching process that the Provider is trying to appeal.[6] Since the only matter specifically revised in the revised NPRs were adjustments related to realigning the SSI percentage from federal fiscal year to the provider fiscal year, the Provider does not have a right to appeal ***from the RNPR at issue***[7] under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the SSI Accuracy issue and Part C Days issues. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[8]

In summary, the Board finds that, since the Provider does not have a right to appeal either issue pending in this appeal, the Board does not have jurisdiction over either of these issues and hereby dismisses them from this appeal. As these issues are no longer pending in this case, the Board hereby denies the transfer of the SSI ratio and Part C days in the SSI ratio issues to Case Nos. 18-0532G and 18-0533G, respectively.

As no issues remain pending in the appeal, the Board hereby closes Case No. 20-0616 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

<u>Board Members Participating</u>:

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Robert A. Evarts, Esq.
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For the Board:

3/3/2021

X Clayton J. Nix

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Board Chair
Signed by: Clayton J. Nix -A

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

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that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] *See supra* note 5.

[7] The Provider could have appealed these two issues from the original NPR and apparently did so for one of these issues as the MAC alleged and the Provider conceded that it has a duplicate appeal pending for one of the issues. The Board notes that the Provider's pursuit of the duplicate appeal violates Board Rule 4.6.2 which is entitled "Same Issue from Multiple Determinations" and prohibits providers from pursuing the same issue for the same year in multiple cases. The Provider has proposed to remedy this violation by consolidating the appeals. This is now moot.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Jurisdictional Challenge***
Mount Pleasant Hospital (42-0104)
FYE: 12/31/2011
PRRB Case: 15-2536

Dear Mr. Ravindran and Ms. Polson,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over Issue 1, DSH – Percentage (Provider Specific). The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On October 30, 2014, the Provider was issued a final Notice of Program Reimbursement ("NPR") for fiscal year ending December 31, 2011.

The Provider filed an individual appeal request with the Board on May 1, 2015. The Individual Appeal Request contained eight (8) issues which all concerned components of the Medicare disproportionate share percentage:

- Issue 1: Disproportionate Share Hospital Payment – SSI Percentage (Provider Specific)
- Issue 2: Disproportionate Share Hospital ("DSH") – SSI Income (Systemic Errors)
- Issue 3: Disproportionate Share Hospital Payment – SSI Fraction/Medicare Managed Care Part C Days
- Issue 4: Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
- Issue 5: Disproportionate Share Hospital Payment – Medicaid Eligible Days
- Issue 6: Disproportionate Share Hospital Payment – Medicaid Fraction/Medicare Managed Care Part C Days

Issue 7: Disproportionate Share Hospital Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
Issue 8: Outlier Payments – Fixed Loss Threshold

The Provider requested to transfer numerous issues to group appeals, including the SSI Systemic Errors issue to Case No. 14-4265GC, Carolina Healthcare System 2011 DSH/SSI Baystate Errors CIRP Group. On February 3, 2021, the Provider requested to withdraw the Medicaid Eligible Days issue pursuant to a reopening.

Following all of the transfers and withdrawals, the ***sole*** remaining issue in this appeal is Issue 1.

Medicare Contractor Jurisdictional Challenge

On June 1, 2018, the Medicare Contractor filed a jurisdictional challenge with the Board over two issues: (1) DSH SSI Provider Specific and (5) Disproportionate Share Hospital Payment – Medicaid Eligible Days.[1] As Issue 5 was withdrawn, only the Jurisdictional Challenge as it relates to Issue 1 remains relevant.

The Medicare Contractor argues that "the DSH SSI%-Provider Specific [*i.e.*, Issue 1] and the DSH SSI%-Systemic [*i.e.*, Issue 2] are considered the same issue by the PRRB, and as such, the issue cannot be in two cases at the same time." The Medicare Contractor notes that the DSH SSI Percentage (Systemic Errors) was transferred to Case No. 14-4265GC. Therefore, The Medicare Contractor asks that Issue 1 be dismissed as it is duplicative of Issue 2 that is being pursued in the group appeal.[2]

Provider Response to the Jurisdictional Challenge

On June 28, 2018, the Provider responded to the Jurisdictional Challenge and contends that Issues 1 and 2 are separate and distinct issues.

Board Decision

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

As set forth below, the Board dismisses Issue 1, DSH Payment – SSI Percentage (Provider Specific), in its entirety. The jurisdictional analysis for this issue has two relevant aspects to

[1] The Medicaid Eligible Days issue was withdrawn on February 3, 2021.
[2] Medicare Contractor Jurisdictional Challenge at 2 (June 1, 2018).

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 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 Issue 2, DSH/SSI (Systemic Errors), in Case No. 14-4265GC to which the Provider transferred the SSI Systemic Errors issue.

The DSH Payment – SSI Percentage (Provider Specific) issue in the present appeal concerns how the SSI percentage was generated by the Social Security Administration (SSA). The Provider 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)." The Provider further states that the SSI percentage computed by CMS was incorrect since it "failed to include all patients that were entitled to SSI benefits in their calculation" and that "[t]he 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."[3]

The Provider transfer Issue 2 (DSH/SSI (Systemic Errors)) to group Case No. 14-4265GC. Issue 2 also alleges that the Medicare Contractor and CMS improperly determined the Medicare reimbursement pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider states that the incorrect reimbursement was calculated according to "a new methodology inconsistent with the Medicare statute" and challenges itss SSI percentage based, in part, on "Availability of MEDPAR and SSA records," "Not in agreement with provider's records," and "Fundamental problems in the SSI percentage calculation."[4] The issue statement for the group to which the Provider transferred issue 2 (Case No. 14-4265GC) is essentially the same but with more detail. The issue statement is entitled "SSI Fraction Calculation/Baystate Errors/§951" and it characterizes "CMS's computation of the SSI percentage as being substantially understated due to systemic errors in the data used to calculate the numerator and denominator of the SSI fraction and the matching process."

Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[5] The Provider is misplaced in stating that the regulatory challenge is related to any "provider specific" SSI issue that could possibly remain in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider

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[3] Appeal Request Issue Statement at 1 (May 1, 2015).
[4] Indeed, the appeal request also included a duplicate set of issue statements where the Issue 1 and 2 were presented as one issue entitled "Self disallowed: SSI Percentage (Provider Specific & Systemic)" and the description contained no distinction between "specific" vs. "systemic."
[5] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue. Accordingly, the Board must find that they are the same issue.

Thus, the Board finds that the DSH Payment – SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH – SSI Income (Systemic Errors) in Case No. 14-4265GC. Because this 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 Payment – SSI Percentage (Provider Specific) issue.

The second aspect of this issue is the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. The Provider preserving its right to request realignment of the SSI should be dismissed by the Board due to 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 appeal. Without a final determination, the dissatisfaction requirement cannot be met for the Board to have jurisdiction, therefore the Board finds that it lacks jurisdiction over the DSH Payment – SSI Percentage (Provider Specific) issue.

Conclusion

Based on the above, the Board dismisses Issue 1, DSH Payment – SSI Percentage (Provider Specific) issue, in its entirety. As no issues remaining pending, the Board herby closes Case No. 15-2536 and removes it from the Board's docket.

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

Board Members Participating:

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For the Board:

3/5/2021

X Clayton J. Nix

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Chair
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Ronald S. Connelly, Esq.
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RE: ***EJR Determination***
20-1639GC Yale-New Haven CY 2017 Miscalculation of DGME FTE Cap & Resident Weighting Factor Group
20-1837GC Banner Health FY 2018 Miscalculation of DGME FTE Cap & Resident Weights Group

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' August 28, 2020 request for expedited judicial review ("EJR") for the two above-caption common issue related party ("CIRP") groups. The decision of the Board is set forth below.

Effect of COVID -19 on Board Operations and Staying of the 30-day Period to Respond to EJR Requests:

By letter dated April 4, 2020, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for these two CIRP groups consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services ("CMS") required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On April 9, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, whether 'a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR." 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned CIRP group appeals.

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on August 28, 2020, the Board and its staff were teleworking. The

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

EJR Request

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] [t]he 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:

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]

These appeals concern the first component of the DGME payment calculation—the resident FTE count.

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:

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[1] Providers' EJR request at 1-2.
[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).
[5] 42 U.S.C. § 1395(h).

> (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:

> [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."

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[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).

[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.

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 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. . . .
>
> *****

[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> 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*** *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.

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[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 66 Fed. Reg. 39826 (Aug. 1, 2001).
[12] *Id.* at 39894 (emphasis added).

§ 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]

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.

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[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.")
[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).

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)(ii)-(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] 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.

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[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).
[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).

Third, in some situations, as demonstrated by the Table on page 13 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. Compliance with requirements for filing a Board appeal

The Providers in this case are appealing based on the Medicare Contractor's failure to issue a timely final determination under the provisions of 42 C.F.R. § 405.1835(c). This regulation permits a provider to file an appeal with the Board where:

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's *perfected cost* report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .[25]

[25] (emphasis added).

The Providers' documentation demonstrates that the timely filing requirements of the regulation have been met and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[26] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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

The Providers appealed from the Medicare Contractors failure to time issue a final determination for covering cost reporting periods ending September 30, 2017 and December 31, 2018, and are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[27] 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 with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[28]

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"[29] 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.[30] Here, no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[31] and the factual record regarding the provider's "compliance" appears to be complete and

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[26] *See* 42 C.F.R. § 405.1837.
[27] 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").
[28] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[29] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[30] *See* 42 C.F.R. § 405.1873(a).
[31] 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."

uncontroverted.[32] 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 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:

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}$$ [33]

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.[34] 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.[35] 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).

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[32] The Board recognizes that the Providers' cost reports included a claim for the disputed DGME payment as a protested amount in their as-filed cost reports as evidenced by Tab D of the jurisdictional documents for each Provider which accompanied the Schedule of Providers. The Providers each included a summary of their Protested amounts which included the DGME calculation and a copy of Worksheet E, Part A which demonstrated the Providers claimed a protested amount.

[33] EJR Request at 4.

[34] *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.)).

[35] 66 Fed. Reg. at 39894 (emphasis added).

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 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].[36]

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.[37] 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."[38] 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[39] (*i.e.*, ratios) using variables a, b, c, and d:

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

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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[36] (Emphasis added.)
[37] *See* 62 Fed. Reg. at 46005 (emphasis added).
[38] *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.)).
[39] 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.[40]

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 these appeals are entitled to a hearing before the Board;

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[40] 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' requests 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 these cases, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

3/10/2021

X Clayton J. Nix

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

Enclosures: Schedule of Providers

cc: Pam VanArsdale, NGS
John Bloom, Noridian Healthcare Solutions
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Randi Deckard
Besler Consulting
2 Independence Way, Ste. 201
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RE: ***Request for Expedited Judicial Review***

19-2293G	Besler Consulting CY 2014 Medicaid Expansion Days Group
19-2099GC	BS&W Health CY 2014 Medicaid Expansion Days CIRP Group
19-1910GC	UHS CY 2014 Medicaid Non Expansion Days CIRP Group
19-2040GC	Cape Fear Valley Health CY 2014 Medicaid Expansion Days CIRP Group
19-2009GC	BS&W Health CY 2015 Medicaid Expansion Days CIRP Group
20-1682GC	Integris Health CY 2015 Medicaid Expansion Days CIRP Group
19-2152GC	Houston Methodist CY 2015 Medicaid Expansion Days CIRP Group
19-1585GC	UHS CY 2015 Medicaid Expansion Days CIRP Group
19-2270G	Besler Consulting CY 2015 Medicaid Expansion Days Group
19-2274GC	Baptist Health System CY 2016 Medicaid Expansion Days CIRP Group
19-2572GC	CoxHealth CY 2016 Medicaid Expansion Days CIRP Group

Dear Ms. Deckard:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' November 25, 2020 request for expedited judicial review ("EJR") in the above-referenced eleven (11) appeals.[1] The Board's decision with respect EJR is set forth below.

Issue:

> The Providers in these groups seek "to include in their second disproportionate share hospital (DSH) computation additional days attributable to individuals who were made 'eligible' for Medicaid under the Medicaid expansion provisions of the Affordable Care Acts of 2010, adding 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)."[2]

[1] The original EJR request included 21 cases. 10 of the cases involved FYEs that began on or after January 1, 2016. As a result, these 10 cases are subject to the substantive claim requirements of 42 C.F.R. §§ 413.24(j) and the Board did not include them in this determination. Rather, the Board is concurrently issuing under separate cover a Scheduling Order for these 10 cases and will later render a separate decision on the EJR request as it relates to these 10 cases.

[2] Groups' Brief in Support of Request for Expedited Judicial Review, 1 (Nov. 25, 2020).

Background:

The Providers filed this EJR request on November 25, 2020, and it was stayed under the Board's Alert 19 policy. As further explained below, the hospitals in this case are located in States which did not expand their Medicaid programs under the relevant provisions of the Patient Protection and Affordable Care Act of 2010 but wish to include individuals who would have been eligible for Medicaid under the expansion provisions in the Medicaid fraction of the DSH calculation.

A. Medicare DSH Payment

Part A of the Medicare Program 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, the Medicare Program pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4] The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

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

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

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

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

> 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 and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[11]

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

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

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

B. The Affordable Care Act – Medicaid Expansion Provisions

The Patient Protection and Affordable Care Act[14] was amended by the Health Care and Education Reconciliation Act of 2010,[15] and *together* these laws are referred to as the Affordable Care Act ("ACA"). In addition, § 205 of the Medicare & Medicaid Extenders Act of 2010[16] made technical corrections to the Social Security Act ("the Act") to implement the ACA.[17] The purpose of this legislation was to increase the number of Americans covered by health insurance and decrease the cost of healthcare.[18] The laws enacted under this statute affected many aspects of health care coverage including the Medicaid Program which is authorized under Title XIX of the Act and was enacted in 1965 along with the Medicare Program which is authorized under Title XVIII of the Act. All states, the District of Columbia, and U.S territories have each implemented a Medicaid program for its respective territory that provides health coverage to low income people.[19] Relevant here are the Medicaid expansion provisions which added 42 U.S.C. § 1396a(a)(10)(A)(VII). This statute states that:

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[10] (Emphasis added.)
[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] Pub. L. 111-148, 124 Stat. 119 (2010).
[15] Pub. L. 111-152, 124 Stat. 1029 (2010).
[16] Pub. L. 111-309, 123 Stat. 3285 (2010).
[17] 77 Fed. Reg. 17444, 17145 (Mar. 23, 2012).
[18] *National Federation of Independent Business et al. v. Sebelius,* 567 S.Ct. 519 (2012).
[19] *See* http://www.Medicaid.gov/about-us/program-history/index.html (last visited January 4, 2021).

> A State plan for medical assistance must—
>
> *****
>
> (10) provide—
> (A) for making medical assistance available, including at least the care and services . . . of this title to—
>
> (VIII) beginning January 1, 2014, who are under the 65 years of age, not pregnant, not entitled to, or enrolled for, benefits underpart A of subchapter XVIII, or enrolled for benefits under Part B of subchapter XVIII, and are not described in a previous subclause of this clause, and whose income . . . does not exceed 133 percent of the poverty line. . . applicable to a family of the size involved. . . .

In conjunction with the expansion of the Medicaid eligible beneficiaries described above, 42 U.S.C. § 1396c (Operations of State Plans) penalized States which did not expand their Medicaid programs. This statute requires, as a general rule, that:

> If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—
>
> (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision;
>
> the Secretary shall *notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply*. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).[20]

Essentially, under this statute, States which failed to comply with the Medicaid expansion mandate could lose part or all of their Federal funding for Medicaid.

[20] 42 U.S.C. § 1395c (emphasis added).

C. Supreme Court Litigation on ACA

Numerous states and the National Federation of Independent Businesses challenged in the federal court system, two provisions of ACA – the individual mandate[21] and the Medicaid expansion. The Supreme Court ultimately addressed these issues in *National Federation of Independent Businesses v. Sebelius* ("*NFIB*").[22] Relevant to the issue before the Board is the Court's decision with respect to Medicaid expansion.

In *NFIB,* the Court noted that the Medicaid expansion provisions of ACA required States to expand their Medicaid programs no later than 2014 to cover all individuals under age 65 with incomes below 133 percent of the federal poverty line.[23] Further, ACA provided that the expanded Medicaid benefits would include benefits sufficient meet the requirements of the individual mandate.[24] The Federal Government would initially pay 100 percent of the costs through 2016, with payments gradually deceasing to a minimum of 90 percent.[25] However, the States argued that the Medicaid expansion exceeded Congress' authority under the Spending Clause. They claimed Congress was coercing the States to adopt the changes by threatening to withhold all of a State's Medicaid grants unless the States accept the new conditions.[26]

The Supreme Court found that the Medicaid expansion portion of ACA violated the Spending Clause of the Constitution by threatening existing Medicaid funding. The Court explained that Congress does not have the authority to order States to regulate according to its instructions. Rather, Congress could offer grants to States, but the States must have a choice whether to accept the offer. To remedy this, the Supreme Court precluded the Federal Government from applying the penalty at 42 U.S.C. § 1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion and specifically noted that "[t]he remedy does not require striking down other portions of the Affordable Care Act."[27]

Providers' EJR Request:

The Providers' Issue Statement submitted with the initial appeals argues that the interplay between these ACA provisions and the Supreme Court's *NFIB* decision create a statutory scheme wherein the definition of individuals who are "Medicaid eligible" was greatly and uniformly expanded throughout the nation, but certain states declined to extend Medicaid benefits to this otherwise expanded population. Thus, this new group is, by statute, "Medicaid eligible," but in practice were not "covered under a state medical assistance plan." They claim that the Medicaid fraction has "repeatedly and uniformly been construed to require" inclusion of

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[21] *See* 26 U.S.C. § 5000A.
[22] 567 U.S. 519 (2012).
[23] *Id.* at 576 (citing 42 U.S.C. § 1396a(10)(A)(i)(VIII)).
[24] *Id.* The individual mandate is found at 42 U.S.C. §§ 1396a(k)(1), 1396u-7(b)(5), and 18022(b)).
[25] *Id.*
[26] *Id.* at 575.
[27] *Id.* at 588.

days of persons qualifying for medical assistance, regardless of whether a state actually pays for or covers those days under its medical assistance plan.

The Providers point out that the Secretary's regulations at 42 C.F.R. § 412.106(b)(4) related to the calculation of the Medicaid fraction recognize that days of persons eligible for medical assistance should be included, but refers to ***only*** those days of persons eligible "under an approved State Medicaid plan." This excludes those days for patients who are statutorily designated as "Medicaid eligible" pursuant to 42 U.S.C. § 1396a(a)(10)(A)(VII), but reside in a state that did not expand its medical assistance program to cover them as permitted via the *NFIB* decision (despite the directive found in 42 U.S.C. § 1396c).[28]

The Providers seek to have the Board "recognize the right of hospitals located in non-expansion States to count inpatient days for persons who qualify for Medicaid under the income test of [42 U.S.C. § 1396a(a)(10)(A)(VII)] as statutorily mandated low-income days, even if, in the case of hospitals located within a non-expansion State, those days are *not* 'covered or paid [for] under the State plan.'"[29]

The Providers claim that the definition of, and formula for, the Medicaid fraction found at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) describes days for persons who were "eligible for medical assistance" which has long been judicially recognized as referring to technical eligibility for Medicaid, rather than the actual payment of benefits by a state Medicaid program.[30] Providers insist that, in enacting the ACA, Congress not only expanded medical assistance eligibility, but intended that any patient days for this expanded group would be included in the Medicaid fraction.[31] Indeed, Providers claim that, prior to the *NIFB* decision, this was CMS' expectation, as well.[32] The Supreme Court's decision in *NFIB* did not alter the statutory designation of "Medicaid eligibility" for this expanded population, but merely provided that states could not be penalized if they did not actually cover or actually pay benefits for them.[33] Thus, the Providers conclude that the exclusion of these days from non-expansion states' Medicaid fractions is invalid and unconstitutional. Since they are challenging the validity and constitutionality of the Secretary's regulations *as applied to non-expansion state hospitals*, the Providers believe the Board lacks the authority to grant the relief they seek. As such, they are requesting the Board grant EJR over the Providers in this group.[34]

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[28] Issue Statement.
[29] Group's Brief in Support of Request for Expedited Judicial Review at 4 (July 15, 2020) ("EJR Request").
[30] *Id.* at 11-12 (citing *Emanuel Hosp. and Health Ctr. v. Shalala*, 97 F.3d 1261, 1264 (9th Cir. 1996); *Jewish Hosp. Inc. v. Secretary of HHS*, 19 F.3d 270, 274-75 (6th Cir. 1994); *Deaconess Health Servs. Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996)). *See also Forest Gen. Hosp. v. Azar*, 926 F.3d 221, 228-229 (5th Cir. 2019); *Empire Health Foundation v. Azar*, 958 F.3d 873 (9th Cir. 2020).
[31] EJR Request at 13-14.
[32] *Id.* at 15-16.
[33] *Id.* at 16 (citing *Alaska Legislative Council v. Walker*, Case No. 3A??N-15-09208 CI, Slip. Op. at 12 (Alaska Super. Ct., Mar. 1, 2016) ("*NFIB* created a unique situation where, for the first time, the Social Security Act textually commends states to cover a group but it does not penalize noncomplying states.").
[34] *Id.* at 23.

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), the Board is required to grant an EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

A group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [35]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[36]

A. Jurisdiction: Revised NPRs

In Case No. 19-1910GC, Provider #2 on the Final Schedule of Providers (Aiken Regional Medical Center, Prov. No. 42-0082) appealed from a revised NPR. The sole adjustment referenced was:

- To adjust the Allowable DSH percentage to account for CMS' recalculation of the Provider's SSI percentage. Ref: 42 CFR 412.106(b)(3).

Likewise, in Case No. 19-2270G, Provider #4 on the Final Schedule of Providers (Westchester General Hospital, Prov. No. 10-0284) appealed from a revised NPR. The four adjustments referenced were:

- To adjust the Charity Care Charges and Uninsured Discounts for the entire facility to agree to the Provider's submitted listing;
- To Adjust the Patient Payments and Uninsured Discounts for the entire facility to agree to the Provider's submitted listing;
- To adjust charges for patient days beyond indigent care program LOS limit to agree to the Provider's submitted listing; and

[35] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[36] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

- To adjust the Charity Care Charges and Uninsured Discounts for the entire facility Charity Care testing results.

The only regulations referenced in all of these adjustments is 42 C.F.R. § 412.106(f)-(h).

Regarding appeals from revised NPRs, 42 C.F.R. § 405.1889(a) (as revised May 23, 2008) explains that a revised NPR "must be considered a separate *and* distinct determination." Further, § 405.1889(b) explains that, as a prerequisite for Board jurisdiction, the issue on appeal must have been "specifically revised."[37] To this end, 42 C.F.R. § 405.1835(a) specifies that the right to appeal a final determination reopened under § 405.1885 "must be limited ***solely*** to those matters that are specifically revised in the contractor's revised final determination" and cross-references § 405.1889(b).[38]

None of the adjustments for either Provider noted above that appealed from a revised NPR are related to Medicaid Expansion Days much less the Medicaid fraction as used in the DSH adjustment calculation (*i.e*., there was no adjustment that "specifically revised" the matter at hand). As such, neither Provider had appeal rights under 42 C.F.R. §§ 405.1889(b) as referenced by 405.1835(a)(1) to appeal the Medicaid expansion issue from their respective revised NPRs and, as a consequence, the Board hereby dismisses them from their respective cases. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[39]

B. Jurisdiction over the Remaining Participants Based on CMS Ruling 1727-R

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[40] 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.[41]

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[37] 42 C.F.R. § 405.1885, 1889 (following August 21, 2008) ("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." (emphasis added)).
[38] (Emphasis added.)
[39] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[40] 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.).
[41] *Bethesda at 1258-59.*

On August 21, 2008, new regulations governing the Board were effective.[42] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[43] 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.[44]

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

The Board has determined that the ***remaining*** participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. Since 42 C.F.R. § 412.106(b)(4)(i) only permits inclusion of patient days in the Medicaid fraction if they are "eligible for Medicaid," defined as eligible for inpatient hospital services "under an approved State Medicaid plan" or "under a waiver authorized under 1115(a)(2) of the [Social Security] Act," the Board finds that the Provider's Medicaid Expansion 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."[45] Notwithstanding the Providers' allegation that the *NFIB* decision otherwise expanded the statutory definition of "eligible for Medicaid," 42 C.F.R. § 412.106(b)(4)(i) does not permit these Medicaid Expansion Days to be included for non-expansion states. This regulation, which binds the Medicare Contractor, only includes days for patients who are "eligible for inpatient hospital services under an approved State Medicaid plan," but non-expansion states do not cover these patients under their approved Medicaid plans.

[42] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[43] 201 F. Supp. 3d 131 (D.D.C. 2016)
[44] *Banner* at 142.
[45] CMS Ruling 1727 at unnumbered page 6.

C. Jurisdiction Summary

The participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[46] The appeals were timely filed and the issue is governed by CMS Ruling 1727. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers, except for the two participants noted above which appealed from revised NPRs. Furthermore, since the remaining Providers are challenging the validity of 42 C.F.R. § 412.106(b) as it relates to including Medicaid Expansion Days in the Medicaid fraction, the Board lacks the authority to provide the relief sought by these Providers.

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 group appeal are entitled to a hearing before the Board with the exception of:

    a. Aiken Regional Medical Center (Prov. No. 42-0082) in Case No. 19-1910GC; and

    b. Westchester General Hospital (Prov. No. 10-0284) in Case No. 19-2270G;

2) Based upon the participants' assertions regarding inclusion of Medicaid Expansion Days in the Medicaid Fraction of the DSH formula, 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 definition of "eligible for Medicaid" in 42 C.F.R. § 412.106(b)(4), which implements, in part, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), is invalid because it fails to include individuals who "are mandatorily 'eligible' for Medicaid as a matter of federal statutory law [at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) as added by ACA § 2001(a)], yet are not 'covered under a state medical assistance plan' in states electing to forego expanded coverage without penalty in light of the [Supreme Court's] decision in *NFIB*."[47]

Based on the above findings, the Board concludes that the above question concerning the validity of 42 C.F.R. § 412.106(b)(4) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and that the Board lacks the authority to provide the relief sought by the Providers (*i.e.*, to include in the Medicaid fraction of the DSH adjustment calculation those days attributable to individuals

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[46] *See* 42 C.F.R. § 405.1837.
[47] EJR Request at 2-3.

who "are mandatorily 'eligible' for Medicaid as a matter of federal statutory law [at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) as added by ACA § 2001(a)], yet are not 'covered under a state medical assistance plan' in states electing to forego expanded coverage without penalty in light of the [Supreme Court's] decision in *NFIB*." [48]). Accordingly, the Board hereby grants their request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these 11 group cases.

Board Members Participating:

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

FOR THE BOARD:

3/10/2021

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

Enclosures: Schedules of Providers

cc: Cecile Huggins, Palmetto GBA (J-J)
Justin Lattimore, Novitas Solutions, Inc. (J-H)
Bruce Snyder, Novitas Solutions, Inc. (J-L)
Laurie Polson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Geoff Pike, First Coast Service Options, Inc. (J-N)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong. Esq., FSS

[48] *Id.* at 2-3.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: N2-19-25
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Mr. Shaw Seely
Baptist Health System
800 Prudential Drive
Jacksonville, FL 32207

Mr. Geoff Pike
Senior Auditor
First Coast Services Options, Inc.
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32202

RE: ***Untimely Filing of Appeal***
Baptist Medical Center – Beaches (10-0117)
FYE – 9/30/2017
PRRB Case No.: 21-0895

Dear Messrs. Seely and Pike:

The Provider Reimbursement Review Board ("Board") reviewed the above-captioned appeal that was electronically filed via the Office of Hearings Case and Document Management System ("OH CDMS"). The subject appeal was submitted by the Provider on February 26, 2021 and is based on the Notice of Program Reimbursement ("NPR") dated July 23, 2020 for the Provider's fiscal year ended September 30, 2017. The appeal identified sixteen (16) issues in dispute.

FACTS:

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**.

Board Rule 4.3.1 states, in part:

> The date of receipt of a contractor final determination is presumed to be 5 days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).
>
> The appeal period begins on the date of receipt of the contractor final determination as defined above and ends 180 days from that date.

Board Rule 4.5.A states, in part:

> Timely filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be:
>
> A. The date submitted to OH CDMS as evidenced by the Confirmation of Correspondence generated by the system.

The final determination in dispute is an NPR which is dated July 23, 2020. The Provider is presumed to have received the NPR 5 days later, July 28, 2020 (See Board Rule 4.3.1.) The calculation of 180 days from July 28, 2020 was January 24, 2021 (which was a Sunday). Pursuant to Board Rule 4.4.3, "If the due date falls on a Saturday, Sunday, a Federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner, the deadline becomes the next business day that is not one of the aforementioned days. *See* 42 C.F.R. § 405.1801(d)(3)." The subject appeal request should have been filed no later than Monday, January 25, 2021 pursuant to the rules cited above.

As noted above, the subject appeal was filed electronically through the OH CDMS system with an official submittal date of February 26, 2021, which is 218 days from the date of the NPR. The Board hereby determines that the subject appeal was not timely filed in accordance with the Board Rules and 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840. The Board hereby dismisses case number 21-0895, in its entirety, and removes it from its docket.

<u>Board Members:</u>

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

FOR THE BOARD:

3/10/2021

X Gregory H. Ziegler

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

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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7500 Security Boulevard
Mail Stop: N2-19-25
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<u>Via Electronic Delivery</u>

Mr. Shaw Seely
Baptist Health System
800 Prudential Drive
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Mr. Geoff Pike
Senior Auditor
First Coast Services Options, Inc.
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32202

RE: ***Untimely Filing of Appeal***
Baptist Medical Center – Jacksonville (10-0088)
FYE – 9/30/2012
PRRB Case No.: 21-0919

Dear Messrs. Seely and Pike:

The Provider Reimbursement Review Board ("Board") reviewed the above-captioned appeal that was electronically filed via the Office of Hearings Case and Document Management System ("OH CDMS"). The subject appeal was submitted by the Provider on March 1, 2021 and is based on the Notice of Program Reimbursement ("NPR") dated July 10, 2020 for the Provider's fiscal year ended September 30, 2012. The appeal identified twenty-two (22) issues in dispute.

<u>FACTS:</u>

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**.

Board Rule 4.3.1 states, in part:

> The date of receipt of a contractor final determination is presumed to be 5 days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).
>
> The appeal period begins on the date of receipt of the contractor final determination as defined above and ends 180 days from that date.

Board Rule 4.5.A states, in part:

> Timely filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be:
>
> A. The date submitted to OH CDMS as evidenced by the Confirmation of Correspondence generated by the system.

The final determination in dispute is an NPR which is dated July 10, 2020. The Provider is presumed to have received the NPR 5 days later, July 15, 2020; 180 days from July 15, 2020 was January 11, 2021. (*See* Board Rule 4.3.1.)

As noted above, the subject appeal was filed electronically through the OH CDMS system with an official submittal date of March 1, 2021, which is 234 days from the date of the NPR. The Board hereby determines that the subject appeal was not timely filed in accordance with the Board Rules and 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840. The Board hereby dismisses case number 21-0919, in its entirety, and removes it from its docket.

<u>Board Members:</u>

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

FOR THE BOARD:

3/10/2021

X Gregory H. Ziegler

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

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Daniel J. Hettich, Esq.
King & Spalding, LLP
1700 Pennsylvania Ave. NW
Suite 200
Washington, D.C. 20006-2706

RE: ***EJR Determination***
13-1789 St. Mary's Medical Center, Provider No. 51-0007, FYE 9/30/2006,

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's March 1, 2021 request for expedited judicial review ("EJR") for the appeal referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue for which EJR was requested in this appeal is:

> Whether the Centers for Medicare & Medicaid Services ("CMS") unlawfully interprets "entitled to benefits under Part A" as encompassing days that are so not entitled to payment under Part A, such as exhausted coverage patients days and Medicare Secondary payor days, in the Medicare disproportionate share hospital ("DSH") payment statute. . . .("2005 Rule"). . . .[1]

Statutory and Regulatory Background

A. Adjustment for Medicare DSH

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

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

The statutory provisions governing IPPS contain 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 IPPS 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 part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[11]

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[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).
[11] (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.[12]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[13] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[14]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[15] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[16] The Secretary then summarized its policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[17]

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[18] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[19] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A

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[12] 42 C.F.R. § 412.106(b)(4).
[13] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.* at 27207-27208.
[18] *Id.* at 27207-08.
[19] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.

coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[20]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[21] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[22] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [23] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[24]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[25] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[26]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[27]

In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital

[20] 68 Fed. Reg. at 27208.
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[26] *Id.*
[27] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[28]
>
> ****
>
> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation.*[29]

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[30] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[31] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[32]

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[28] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[29] *Id.* at 49099 (emphasis added).
[30] *Id.*
[31] *See id.* at 49099, 49246.
[32] (Emphasis added.)

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[33]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[34]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[35] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[36] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[37] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[38] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[39] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[40] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[41] found that the Secretary's interpretation that that an individual is "entitled to

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[33] (Emphasis added.)
[34] *Id.*
[35] 317 F. Supp. 3d 168 (D.D.C. 2018).
[36] *Id.* at 172.
[37] *Id.* at 190.
[38] *Id.* at 194.
[39] *See* 2019 WL 668282.
[40] 718 F.3d 914 (2013).
[41] 657 F.3d 1 (D.C. Cir. 2011).

benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[42]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[43] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[44] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[45] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate contest in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[46] and that the regulation is procedurally invalid.[47]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[48] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[49] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[50] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[51] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[52] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[53] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to

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[42] 718 F.3d at 920.
[43] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[44] *Id.* at 1141.
[45] *Id.*
[46] *Id. at 1162.*
[47] *Id. at 1163*
[48] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir., Oct. 20, 2020). It is unclear if the Secretary will petition the U.S. Supreme Court to review the Ninth Circuit's *Empire* decision.
[49] *Id.* at 884.
[50] *Id.* at 884.
[51] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[52] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[53] *Id.* at 886.

[Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[54] Accordingly, the Ninth Circuit to the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force).

As of the date of this decision, the Secretary's position with respect to the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

Provider's Request for EJR

The Provider points out that the Secretary[55] originally interpreted the terms "eligible" and "entitled" to mean paid by Medicaid or Medicare, respectively.[56] However, in August 2004, the Secretary published the 2005 Rule adopting a policy change to count the days that were not entitled to receive payment under Medicare Part A, such as exhausted benefits days and Medicare secondary payor days, as being days "entitled to" Medicare Part A for purposes of the DSH calculation. The Provider notes that this policy had the effect of including all exhausted or Medicare secondary payor days in the SSI fraction and excluding dual eligible exhausted or Medicare secondary payor days from the Medicaid fraction. The adoption of this policy was accomplished by deleting the word "covered" where it had previously appeared in the definition of the Medicare/SSI fraction at 42 C.F.R. § 412.106(b)(2)(i). Further, in 2007, the Secretary published an additional notice in the Federal Register of a change to the DSH regulation, stating that the Secretary had "inadvertently" forgot to change the text of the regulation in the 2005 Rule and was thus making a "technical correction" to effectuate the change in the DSH policy.[57]

The Provider believes EJR is appropriate for the dual eligible days issue because where the Board has jurisdiction over an appeal, under the provisions of 42 U.S.C. § 1395oo(f)(1) a provider may request EJR where it believes the Board lacks the authority to grant the relief sought. By removing the word "covered" from the regulation and stating in the 2005 Rule, his policy that days for which Part A made no payment, such as exhausted benefits days, remain "days entitled to benefit under Part A," the Secretary bound the Board to this outcome.

The Provider does not believe that the Ninth Circuit's decision in *Empire* is likely to change the Board's opinion in this regard. While the Provider believes that the Ninth Circuit's *vacatur* of CMS's policy in *Empire* is national in scope, meaning that the Provider should get the benefit of that decision even though it is in the Fourth Circuit's jurisdiction and the Secretary of HHS has

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[54] *Id.*
[55] of the Department of Health and Human Services.
[56] *See* 51 Fed. Reg. 16772, 16788 (May 6, 1986).
[57] *See* 72 Fed. Reg. 47130, 47387 (Aug. 22, 2007).

taken a contrary position that Empire is only binding in the Ninth Circuit. Given the Secretary's position, and that there has been no authoritative court decision explicitly stating that the Ninth Circuit's *vacatur* is national in scope, the Provider maintains the Board would still find itself bound by CMS's 2005 Rule. The Provider therefore asks for an EJR determination from the Board on this issue.

<u>Decision of the Board</u>

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

<u>Jurisdiction</u>

The Provider in this case, within this EJR request, filed from a revised NPR determination involving fiscal year 2006. For any provider that files an appeal from a revised NPR issued *after* August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor "specifically revised" within the revised NPR.[58] The Board notes that the revised NPR in this appeal was issued *after* August 21, 2008 (March 5, 2013).

The revised NPR at issue had adjustments to the SSI percentage which included revisions to the dual eligible days, as required for jurisdiction under the provisions of 42 C.F.R. § 405.1889.[59] In addition, the participant's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal[60] and the appeal was timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount. Accordingly, the Board finds jurisdiction over the Provider for the issue underlying the EJR request.

<u>EJR</u>

The Board finds that it lacks the authority to grant the relief sought by the Provider to apply the Ninth Circuit's decision in *Empire*. More specifically, the Board lacks the authority to make findings consistent with the Ninth Circuit's decision in *Empire* that 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not substantively valid and, thereby, reinstate the version of 42 C.F.R. § 412.106(b)(2)(i) previously in force prior to the FY 2005 IPPS final rule. Consequently, the Board concludes that EJR is appropriate.

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[58] See 42 C.F.R. § 405.1889(b)(1) (2008).
[59] The Board notes that the Provider's request for relief is to apply the Ninth Circuit's decision in *Empire* and, as such, the relief requested only entails reverting back to the policy in effect prior to the FY 2005 IPPS Final Rule. The Provider is not seeking any changes to the DSH calculation beyond that.
[60] *See* 42 C.F.R. § 405.1835.

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

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) codifying the Medicare dual eligible days policy adopted in the FY 2005 IPPS final rule is valid and to provide the requested relief to reinstate the version of 42 C.F.R. § 412.106(b)(2)(i) previously in force prior to the FY 2005 IPPS final rule consistent with the Ninth Circuit's decision in *Empire*.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (2005) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the 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 last issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

3/16/2021

X Clayton J. Nix

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

cc: Laurie Polson, Palmetto GBA c/o NGS
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Decision***
Sanford Medical Center Fargo
FYE 9/30/2015
Case No. 15-1289

Dear Ms. Webster,

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

Pertinent Facts:

The Provider filed its appeal request on January 30, 2015, appealing from a Federal Register published on August 22, 2014.[1] That publication included the amount of the DSH payment for all hospitals for FFY 2015, and the Provider seeks correction of that final payment amount. The Provider first argues that the estimates used to calculate their UCC DSH payment were based on data that had been superseded by later available data. This violates the statutory mandate at 42 U.S.C. § 1395ww(r)(2)(C) which requires the estimates be based on appropriate data. The Provider also believes the 2015 Final Rule is procedurally invalid because CMS did not provide adequate notice of the ultimate data choice.[2] Specifically, the Provider argues that its UCC DSH payment was calculated based on 20,386 Medicaid eligible days, when the figure should have been 21,469.[3]

With regard to the statutory bar on administrative review found at 42 U.S.C. § 1395ww(r)(3), the Provider says it does not preclude review of (1) the Secretary's determination of the DSH uncompensated care payment amounts, (2) the Secretary's choice of data in making that determination, or (3) the regulation fixing the calculation of those payment amounts at the time when the secretary promulgated the final IPPS rule for 2014. To the extent that the bar does preclude Provider's appeal, it alleges that "the preclusion review of the provision of the final rule

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[1] 79 Fed. Reg. 49854 (Aug. 22, 2014).
[2] Individual Appeal Request, Statement of Issue at 1.
[3] *Id.* at 2.

would be invalid because it would violate the due process and separation of powers requirements of the Constitution."[4]

Relevant Law and Analysis:

Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[5]
(B) Any period selected by the Secretary for such purposes.

Interpretation of Bar on Administrative Review

Tampa General v. Sec'y of HHS

In *Tampa General*, [6] the D.C. Circuit Court upheld the D.C. District Court's decision[7] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[8] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data

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[4] *Id.* at 3.
[5] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[6] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[7] 89 F. Supp. 3d 121 (D.D.C. 2015).
[8] 830 F.3d 515, 517.

because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[9]

The District Court went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[10]

DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court addressed the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar*.[11] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The court disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[12] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that the court had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, it found the same relationship existed with regard to the methodology used to generate the estimates.[13]

Board Decision:

With regard to the argument that the Secretary could have used more accurate or recent data to calculate any portion of Provider's 2015 Uncompensated Care payments, the Board finds that the same findings from *Tampa General* and *DCH v. Azar* are applicable. The Provider is challenging the inclusion and/or exclusion of certain days and/or data in the estimates used by the Secretary. The Board finds in challenging data included or excluded in calculating its Factor 3 values, the Provider is seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board finds that the Provider is specifically challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

Likewise, with regard to any attempt to cast the appeal as a challenge to the procedural validity of the Final Rule because the Secretary failed to provide notice of the agency's ultimate data choice, the Board rejects this argument. The relief sought by the Provider is "correction of [the]

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[9] *Id.* at 519.
[10] *Id.* at 521-22.
[11] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[12] *Id.* at 506.
[13] *Id.* at 507.

final payment amount" for its specific hospital as published in the FFY 2015 IPPS Final Rule. Specifically, the remedy it seeks is to update its Medicaid eligible days from 20,386 to 21,469. The court in *Tampa General* rejected a similar attempt to reframe the challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[14] Since the DSH UCC issue is the only remaining issue in this case, the Board hereby closes the case and removes it from its docket.

Accordingly, the Board dismisses the DSH UCC payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In making this finding, the Board notes that its decision is consistent with the D.C. Circuit's decision in *Tampa General* and *DCH v. Azar* and that these decisions are controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[15]

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

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John Bloom, Noridian Healthcare Solutions (J-F)

[14] 830 F.3d at 521-22.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: N2-19-25
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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services
150 N. Santa Anita Ave., Ste. 570A
Arcadia, CA 91006

RE: ***Reinstatement and EJR Determination***
#2 Providence Holy Cross Medical Center (provider no. 05-0278, FYE 12/31/13)
#4 Providence Tarzana Medical Center (provider no. 05-0761, FYE 12/31/13)
as participants in:
16-0605GC QRS Providence 2013 SSI-Dual Eligible Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Group Representative's January 7, 2021 request to reinstate the two providers referenced above into case number 16-0605GC. In addition, the Providers in this group appeal filed a request for expedited judicial review ("EJR") for the above-referenced common issue related party ("CIRP") group appeal on March 13, 2020, and the Board issued a decision with respect to the remaining Providers in case number 16-0605GC on November 30, 2020.[1] The Board's determination regarding the request for reinstatement and EJR for #2 Providence Holy Cross Medical Center (provider no. 05-0278, FYE 12/31/13) and #4 Providence Tarzana Medical Center (provider no. 05-0761, FYE 12/31/13) is set forth below.

Effect of COVID -19 on Board Operations and Staying of the 30-day Period to Respond to EJR Requests:

By letter dated April 4, 2020, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services ("CMS") required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On April 9, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced

[1] The EJR also included a number of other case numbers. The Board has responded to the original request for EJR in those cases under separate cover.

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

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on March 3, 2020, the Board did not receive the EJR request for the above-referenced appeal in its office until March 13, 2020, after the Board and its staff had begun to telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers submitted March 3, 2020. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

Reinstatement Request

In the case of #2 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/13) and #4 Providence Tarzana Medical Center (Provider No. 05-0761, FYE 12/31/13), the Providers failed to include proof of delivery of their respective hearing requests in the jurisdictional documents accompanying the Schedule of Providers as required by Board Rule 21.3.2.[2] In the case of #2 Holy Cross Medical Center, the Group Representative confirmed on the Schedule of Providers in footnote 1 that it "was unable to locate the delivery notification of the Model Form E." For # 4 Providence Tarzana Medical Center, the Group Representative attached a notice from United Parcel Service ("UPS") that was assigned a shipping number and scheduled for shipment but this notice does ***not*** demonstrate that the package had in fact been delivered (much less that the packaged had been actually received by UPS and sent using that delivery service).[3]

Board Rule 21.3.2 requires that when a Schedule of Providers is filed with the Board each Provider must include:

> A copy of the relevant pages from the initial appeal request (Model Form A or E) and the request to add an issue, if applicable (Model Form C), including the issue statement, or other written requests filed prior to the use of such Model Forms in which this issue was appealed for the first time. In addition, if the appeal was filed after August 21, 2008, include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS

[2] The Board's Rules are found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.
[3] The notice appeared to be what is generated when a shipping label is generated for a shipment using a shipper's website and does not demonstrate that a package was actually received or sent by the shipper.

> tracking) for both the original appeal request and the addition of the issue.[4]

Consequently, the Board dismissed the Providers as part of the jurisdictional determination made in conjunction with the EJR decision in case number 16-0605GC issued on November 30, 2020.[5]

On January 7, 2021, the Group Representative asked that the appeals for #2 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/13) and #4 Providence Tarzana Medical Center (Prov. No. 05-0761, FYE 12/31/13) be reinstated. In conjunction with this request, the Group Representative submitted copies of the UPS proof of delivery for the hearing requests for both Providers.

The Board has reviewed the documentation and agrees with the Group Representative that it demonstrates the required proof of timely filing for these two providers. Accordingly, the Board hereby reopens Case No. 16-0605GC and reinstates #2 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/13) and #4 Providence Tarzana Medical Center (Prov. No. 05-0761, FYE 12/31/13). The Board decision with respect to the Providers' EJR request is set forth below.

EJR Decision

Issue in Dispute:

The group issue statement filed to establish this CIRP group is entitled "Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)" and it contains the following description of the issue:

> Whether patient days associated with Medicare Part A and Title XIX patients should be *excluded* from the SSI or ***Medicare*** fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have excluded from the SSI or ***Medicare*** fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.[6]

The group issue statement then provides the following "Statement of the Legal Basis":

> The Provider contends that the MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI

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[4] The Board notes that this rule is consistent with 42 C.F.R. § 405.1837(a)(1) and (c) that require each provider demonstrate it satisfies individually the requirement for a Board hearing which includes the requirement that an appeal be timely filed with the Board.
[5] Jurisdiction over participants in a group appeal is a perquisite to granting a request for EJR. *See* 42 C.F.R. § 405.1842(a).
[6] (Emphasis added.)

> percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.
>
> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days <u>paid</u> by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. *The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.*
>
> *It is the Provider's contention that these days must be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula.*[7]

The EJR request characterizes the group issue in this CIRP appeal as:

> Whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "*dual eligible*"), and for whom Medicare has not made payment for that inpatient stay (hereinafter referred to as *"noncovered days")* should be included in the Medicare fraction of the *Medicare* Disproportionate Share (DSH) adjustment, as alleged by the MAC [Medicare Administrative Contractor], or should be excluded *Medicare* fraction of the DSH adjustment, and instead included in the *Medicaid* fraction . . . .[8]

The EJR request specifies that the relief being requested is that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is

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[7] (Italics emphasis added and bold and underline emphasis in original.)
[8] Providers' EJR request at 2-3 (emphasis in original).

eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."[9]

Statutory and Regulatory Background: Medicare DSH Payment

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[10] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[11]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[12] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[13]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[14] 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.[15] The DPP is defined as the sum of two fractions expressed as percentages.[16] 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 . . . .[17]

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[9] *Id.* at 1.
[10] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[11] *Id.*
[12] *See* 42 U.S.C. § 1395ww(d)(5).
[13] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[14] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[15] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[16] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[17] (Emphasis added.)

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[18]

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.[19]

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.[20]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[21] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[22]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[23] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[24] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare

[18] 42 C.F.R. § 412.106(b)(2)-(3).
[19] (Emphasis added.)
[20] 42 C.F.R. § 412.106(b)(4).
[21] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[22] *Id.*
[23] *Id.*
[24] *Id.*

fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[25]

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[26] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[27] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[28]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[29] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[30] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [31] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[32]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[33] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[34]

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[25] *Id.* at 27207-27208.
[26] *Id.* at 27207-08.
[27] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[28] 68 Fed. Reg. at 27208.
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[34] *Id.*

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[35]

In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[36]
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> ****
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> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation.*[37]

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[38] In order to effectuate this policy change, the FY 2005

[35] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[36] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[37] *Id.* at 49099 (emphasis added).
[38] *Id.*

IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[39] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of **covered** patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[40]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[41]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[42]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[43] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[44] The D.C. District Court concluded that the

[39] *See id.* at 49099, 49246.
[40] (Emphasis added.)
[41] (Emphasis added.)
[42] *Id.*
[43] 317 F. Supp. 3d 168 (D.D.C. 2018).
[44] *Id.* at 172.

Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[45] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[46] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[47] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[48] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[49] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[50]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[51] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[52] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[53] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate contest in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[54] and that the regulation is procedurally invalid.[55]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[56] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural

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[45] *Id.* at 190.
[46] *Id.* at 194.
[47] *See* 2019 WL 668282.
[48] 718 F.3d 914 (2013).
[49] 657 F.3d 1 (D.C. Cir. 2011).
[50] 718 F.3d at 920.
[51] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[52] *Id.* at 1141.
[53] *Id.*
[54] *Id. at 1162.*
[55] *Id. at 1163*
[56] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir., Oct. 20, 2020). It is unclear if the Secretary will petition the U.S. Supreme Court to review the Ninth Circuit's *Empire* decision.

rulemaking requirements of the APA.[57] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[58] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[59] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[60] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[61] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[62] Accordingly, the Ninth Circuit to the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force).

As of the date of this decision, the Secretary's position with respect to the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

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

The Providers contend that the non-covered patient, *i.e.*, days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make payment for their hospital stays because the patient's Medicare patient days were exhausted or because a third party made payment, should be excluded from the Medicare fraction of the DSH fraction. The Providers maintain *in their EJR request* that these non-covered patient days should be treated consistently: (1) they should be included in both the numerator and denominator of the SSI fraction; or (2) excluded from the numerator and denominator of the SSI fraction and then be recognized in the numerator of the Medicaid fraction.[63]

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[57] *Id.* at 884.
[58] *Id.* at 884.
[59] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[60] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[61] *Id.* at 886.
[62] *Id.*
[63] Providers' EJR Request at 2.

The Providers explain that the applicable regulations require that non-covered patient days be included in the Medicare fraction due to the change made to the regulations effective October 1, 2004. This was accomplished by the deletion of the word "covered" where it had previously appeared in the definition of the Medicare fraction in 42 C.F.R. § 412.106(b)(2)(i). As a result of this change, the regulation now requires the inclusion in the Medicare fraction of both exhausted benefit and Medicare secondary payment days associated with patient discharges occurring on or after October 1, 2004.

The Providers assert that the Secretary improperly promulgated the revision to § 412.106(b)(2)(i) as part of the FY 2005 IPPS Final Rule and that this revision should be vacated due to *procedural* violations of the Administrative Procedures Act ("APA").[64] In support of its position, the Providers note that, in *Allina Health Servs. v. Sebelius* ("*Allina*"), the D.C. Circuit recently invalidated a different regulatory revision made in the same rulemaking.[65] In *Allina*, the D.C. Circuit vacated the Secretary's regulation requiring Part C days be included in the Medicare fraction where the Secretary's policy prior to October 1, 2004 was to exclude Part C days from the Medicare fraction. The D.C. Circuit concluded that the Part C days regulation was not a logical outgrowth of the proposed regulation and that the proposed rule was merely an indication that the Secretary was considering a clarification of existing policy rather a reversal of the existing policy.

The Providers put forward another challenge to the procedural validity of the revision to § 412.106(b)(2)(i) by arguing that the Secretary's FY 2005 regulations requiring inclusion of the non-covered days in the Medicare fraction were not the product of reasoned decision-making.[66] The Providers argue that the dual eligible days proposed rule as published in the FY 2004 IPPS proposed rule was equally misleading with respect to the Secretary's policy. As with the Secretary's Part C days policy, the Secretary adopted a policy with regard to dual eligible days that was the reverse of the proposed regulation and erroneously described the policy with respected to dual eligible days in the FY 2004 IPPS proposed rule. The Provider's contend that the convoluted nature of this rulemaking in which the Secretary both got her facts mixed up while at the same time shifting positions could only create among the public the type of hopeless confusion which the D.C. Circuit found in *Allina.*[67]

Accordingly, the Providers maintain that the Secretary denied the public a meaningful opportunity to comment on the proposed regulations. There was nothing in the proposed regulations that suggested the possibility of anything other than the inclusion of non-covered days in the Medicare fraction or inclusion of non-covered days in the Medicaid fraction. As a result, the Providers maintain, the public was deprived of a meaningful opportunity to comment.

Accordingly, the Providers asserted that the Secretary's regulations requiring inclusion of post-2004 non-covered days in the Medicare fraction must be vacated and, as a result, the pre-FY 2005 regulations would apply.[68] The Providers assert that "These pre-FY 2005 regulations

[64] *Id.* at Section I.B.4.
[65] 746 F. 3d 1102 (D.C. Cir. 2014)
[66] Provider's EJR Request at Section I.B.5.
[67] *Id.* at 1107.
[68] Providers' EJR Request at Section I.B.6.

command exclusion of all non-covered days from the *Medicare* fraction" and that "if those day must be excluded from the Medicare faction [*sic* fraction], then they must necessarily be included in the Medicaid fraction."

The EJR request also puts forward challenges to the substantive validity of the revision to § 412.106(b)(2)(i) in Sections I.B.7. Here, the Providers argue that "[t]he plain and unambiguous language of the Medicare Act mandates exclusion of non-covered days from the Medicare fraction, and inclusion of those days in the Medicaid fraction." The Providers contend that the statutory scheme establishes that Medicare secondary payor days and exhausted benefit days are not "entitled to benefits under Part A."[69]

Finally, the EJR request contends "[a]lternatively . . . that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to included [*sic* include] unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare fraction."[70] In making this "alternative" contention, the EJR request notes that "[t]his contention is a separate and independent basis for granting EJR in this case" and that "the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction."[71]

The Providers point out that there are no factual matters to be resolved with respect to the issue in these cases and the Board has jurisdiction over the appeals. The Providers maintain that EJR is appropriate since the Board is without the authority to grant the relief sought, namely a finding that, as a matter of law , 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid.

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) (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.

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[69] *Id.* at 12 (citing to *Jewish Hosp. v. Secretary of Health & Human Servs.*, 19 F.3d 270 (6th Cir. 1994); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1264 (9th Cir. 1996).
[70] Providers' EJR request at 1.
[71] *Id.*

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*").[72] 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.[73]

On August 21, 2008, new regulations governing the Board were effective.[74] 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*").[75] 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.[76]

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

A. *Jurisdiction Limited to One Issue – the No-Pay Dual Eligible Days Issue*

The Board notes that, on first page of their EJR request, the Providers include another issue which states:

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[72] 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.).
[73] *Bethesda*, 108 S. Ct. at 1258-59.
[74] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[75] 201 F. Supp. 3d 131 (D.D.C. 2016).
[76] *Id.* at 142.

> ***Alternatively***, the provider contends [*sic* providers contend] that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to include unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare Fraction. *This contention is a separate **and** independent basis* for granting EJR in this case. As noted below, the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction.[77]

The Board notes that, pursuant to the regulation, 42 C.F.R. § 405.1837(a)(2), a provider has the right to a hearing as part of a group appeal for a cost reporting period, *only if* among other things, "[t]he matter at issue in the group appeal involves a *single* question of fact or interpretation of law, regulations or CMS Rulings with is common to each provider in the group."[78] To this end, 42 C.F.R. § 405.1837(f) provides "Limitations on group appeals" and specifies in Paragraph (1) that issues may not be added to any group appeals: "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may not add other questions of fact or law to the appeal*, regardless of whether the question is common to other members of the appeal . . . ."[79]

The Board finds that the statement above is a separate issue (as recognized by the Representative through the use of the words "separate and independent" contention) and that the statement above is a new issue that was ***improperly*** added to the appeal when the EJR request was filed. The group statement filed to establish this CIRP group clearly does not challenge how SSI entitlement is determined for purposes of the DSH adjustment calculation or contend that that "eligible but unpaid SSI days be included in the numerator of the Medicare Fraction." Rather, the group appeal challenges how *Medicare* entitlement is determined and asserts that unpaid dual eligible days should be excluded from the Medicare fraction. Since the SSI entitlement days issue is a new issue and was not part of the original group issue statement, the Board is required to dismiss the issue from the group appeal pursuant to 42 C.F.R. § 405.1837(f)(1).[80] Consequently, the Board hereby dismisses the issue from the appeal and denies the EJR request relative to improperly added SSI entitlement days issue.[81]

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[77] (Emphasis added.)
[78] (Emphasis added.)
[79] (Emphasis added.)
[80] Moreover, the Board notes that, even if there was not the prohibition against adding issues to group appeals, the addition of this issue could not be considered timely since: (1) the add issue regulation at 42 C.F.R. § 405.1835(e) only applies to adding issues to individual appeal requests; and (2) the SSI days issue was not added to the group within the 180-day time period, as required by 42 C.F.R. § 405.1837(a)(1) (which incorporates § 405.1835(a) or § 405.1835(c)) and, thus, would not be timely.
[81] The Board further notes that the Provider failed to brief this improperly added issue as part of its EJR request.

B. Scope of Eligible Days Issue Limited to Medicare Fraction

Similar to 42 C.F.R. § 405.1835(b), 42 C.F.R. § 405.1837(c) (2014) specifies that request for a group appeal contain the following:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) An explanation (for each specific item at issue; see §405.1835(a)(1)) of each provider's dissatisfaction with its contractor or Secretary determination under appeal, including an account of—
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item;
>
> (ii) **How and why the provider believes Medicare payment must be determined differently for each disputed item**; and
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement sought for each item.
>
> (3) A copy of each contractor or Secretary determination under appeal, and any other documentary evidence the providers consider necessary to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and **a precise description** of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matters at issue in the group appeal; and
>
> (4) A statement that—
>
> (i) The providers believe they have satisfied all of the requirements for a group appeal hearing request under paragraph (a) of this section and requesting the Board to proceed to make jurisdictional findings in accordance with § 405.1840; or
>
> (ii) The Board is requested to defer making jurisdictional findings until the providers request the findings in accordance with paragraph (e)(2) of this section.

The Providers' issue statement filed to establish this CIRP group only appealed the Medicare fraction and does not dispute the Medicaid fraction.[82] As part of the group appeal request, 42 C.F.R. § 405.1837(c)(2) required the group appeal request to include a "precise description" of the one question of fact or law common to the group and to explain both "how and why" Medicare payment must be determined differently. In compliance with this regulation, the group issue statement only requested the relief that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula."

In this regard, the Providers EJR request tried to analogize to Part C days to support its position that, if the no-pay days are excluded from the Medicare fraction, they must automatically be counted in both the numerator and denominator of the Medicaid fraction. However, the Board notes that, contrary to the Providers assertion, dual eligible days differ from Medicare Part C days. The Medicare Part C days issue deals with the days associated with a class of patients. Either all days associated with Medicare Part C beneficiaries are "entitled" to Medicare Part A or not. If they are not so entitled, then they are included in the Medicaid fraction by the clear terms of the DSH statute as the D.C. Circuit explained in *Allina*.[83]

With regard to the dual eligible days issue, all of the Medicare beneficiaries have Medicare Part A and, as such, it is clear that, as a *patient class*, days associated may not be included *in toto* from the Medicare fraction. Rather, the Providers are asserting that only in certain ***no-pay*** situations (*e.g.*, exhausted benefits and MSP) must these patients be excluded from the SSI fraction. As a result, the Board disagrees with the Providers' assertion that exclusion of days associated with these no-pay situations automatically means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*")[84] and CMS Ruling 1727-R2 wherein multiple possible treatment of dual eligible days are discussed. Indeed, the relief requested appears to be consistent with the Administrator's 2000 decision in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[85]

Based on the above, the Board finds that the Providers' EJR request is limited to the relief requested in the group issue statement, namely that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula." As a result, the Board strikes those portions of the Representative's EJR request requesting the relief that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."

The Board notes that the relief being request in the group issue statement for this CIRP group is not inconsistent with the Ninth Circuit's decision in *Empire* wherein it relied on the Ninth Circuit's earlier decision in *Legacy* to: (1) find that the FY 2005 IPPS Final Rule's revision to 42 C.F.R. § 412.106(b)(2)(i) was *substantively* invalid and (2) reinstate the regulation or rule

[82] The only references to the Medicaid fraction are statements of alleged facts and do not include any assertion that the Medicaid fraction was *incorrectly* calculated (much less express dissatisfaction with the Medicaid fraction).
[83] 746 F.3d at 1108.
[84] 718 F.3d 914 (D.C. Cir. 2013).
[85] *See* 718 F.3d at 918, 92122 (discussing the *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater*").

previously in effect. Rather, the relief requested is seeking to address what *Empire* does not address, namely the regulation or rule previously in effect.[86]

C. Jurisdiction and EJR for the Two Reinstated Providers

The Board has determined that #2 Providence Holy Cross Medical Center (provider no. 05-0278, FYE 12/31/13) and #4 Providence Tarzana Medical Center (provider no. 05-0761, FYE 12/31/13) as participants in case number 16-0605GC and involved with the instant EJR request are governed by CMS Ruling CMS-1727-R as the Providers are challenging the validity of a regulation as it relates to Dual Eligible Days. Finally, the appeals were timely filed and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[87] Based on the above, the Board finds that it has jurisdiction for the above-captioned Providers' appeals. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

The Board finds that it lacks the authority to grant the relief sought by the Providers, namely a finding that 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid. Consequently, the Board finds that EJR is appropriate.

<u>Board's Decision Regarding the EJR Request</u>

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the #2 Providence Holy Cross Medical Center (provider no. 05-0278, FYE 12/31/13) and #4 Providence Tarzana Medical Center (provider no. 05-0761, FYE 12/31/13) in case number 16-0605GC, are entitled to a hearing before the Board;

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

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) codifying the Medicare dual eligible days policy adopted in the FY 2005 IPPS final rule is valid and to provide the requested relief that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula."

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[86] The Board notes that, even though subsequent to the EJR request being filed the Ninth Circuit issued its decision in *Empire*, the Group Representative did not seek to supplement its EJR request (notwithstanding the fact that the Group Representative was the representative for that case when it was before the Board). Rather, the Group Representative filed a request on October 29. 2020 requesting that the Board issue a decision on its EJR request by November 30, 2020.
[87] *See* 42 C.F.R. § 405.1837.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (2005) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants#2 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/13) and #4 Providence Tarzana Medical Center (Prov. No. 05-0761, FYE 12/31/13), as participants in Case No. 16-0605GC, request for EJR for the issue and the subject year as noted above. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board once again closes the case.

Board Members Participating:

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

FOR THE BOARD:

3/16/2021

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Decision***
McLeod Loris/Seacoast Hospital
FYE 9/30/2016
Case No. 16-0773

Dear Mr. Hettich,

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

Pertinent Facts:

The Provider filed their appeal request on January 27, 2016, challenging the Final Rule in the Federal Register issued on August 17, 2015.[1] The Provider's appeal focuses on whether its DSH payment contained a calculation error related to the third factor ("Factor 3") used to determine the payment for its proportion of uncompensated care. Specifically, the Provider has framed two issues as follows:

> *Issue 1:* Whether CMS's failure to use a full 12-month cost reporting period to determine the number of the Provider's Medicaid eligible days in calculating factor 3 of the Provider's uncompensated care ("UCC") payment was lawful?
>
> *Issue 2:* Whether CMS erred and acted beyond its authority, i.e., *ultra vires*, by failing to effectuate the D.C. circuit's *Allina* decision when it calculated factor 3 in the Provider's UCC payment.[2]

For Issue 1, the Provider points out that, for FY 2016, CMS stated it would calculate Factor 3 using data from the "2012 cost report, unless that cost report is unavailable or reflects less than a full 12-month year. In the event the 2012 cost report is for less than 12 months, we will use the cost report from 2012 or 2011 that is closest to being a full 12-month cost report."[3] Rather than using

[1] Individual Appeal Request, Tab 1 (Jan. 27, 2016); 80 Fed. Reg. 49326 (Aug. 17, 2015).
[2] Individual Appeal Request, Tab 3 at 1-3.
[3] *Id.* at 1 (citing 80 Fed. Reg. 49326, 49528-29 (Aug. 17, 2015)).

Provider's full 12-month period that began in 2012, CMS instead used data from a 9-month period ("stub-period") following a change in ownership in 2012.

Provider claims that CMS is statutorily required to calculate the UCC payment for each hospital "for a period selected by the Secretary," and that comparing the days in a stub-period for Provider to a full twelve-month period for other providers employs different "periods" in violation of that statutory requirement.[4] Provider also argues that the use of a stub-period violates the statutory requirement that any "estimate" used by the Secretary be "based on appropriate data." It claims that this practice arbitrarily penalizes certain providers with "stub-periods."[5] Finally, Provider argues that it is not being provided the same protection afforded to Indian Health Service ("IHS") hospitals. It notes that, originally, because cost reports for IHS hospitals are not uploaded to HCRIS, the UCC payments calculated by CMS understated the amount of uncompensated care that IHS hospitals provide. CMS later revised its policy to consider supplemental cost report data in determining Factor 3 to allow the Medicaid days for HIS hospitals to be included.[6]

For Issue 2, Provider discusses *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) ("*Allina*") with regard to the calculation of Factor 3 of the UCC payment, reiterating the argument that SSI days should exclude Medicare Advantage ("MA") days, and MA dual eligible days should be included as Medicaid days in the FY 2016 Factor 3 calculation. Provider points out CMS' position that it does not believe *Allina* has any bearing on the estimate of Factor 3 for FY 2016 since it had readopted the policy of counting MA says in the SSI ration for FY 2014 and beyond. Provider argues that this policy still relies on SSI and Medicaid data from a period predating this re-adopted policy, and that CMS was obligated to correct those numbers to confirm with the Court's ruling in *Allina.* Provider contends that this approach results in CMS acting beyond its authority by continuing to treat Part C days as "days entitled to benefits under Part A" for periods pre-dating their re-adopted policy.[7]

The Medicare Contractor ("MAC") filed a Jurisdictional Challenge in this case on August 1, 2018. The MAC argues that both issues are precluded from administrative and judicial review pursuant to 42 U.S.C. § 1395ww(r)(3). It argues that the "bar against administrative and judicial review is sufficiently broad to defeat the provider's arguments concerning the cost reporting periods used in CMS's calculation and the provider's argument that the agency continues to place the Medicare Part C days in the wrong fraction."[8]

The Provider filed a Response to the MAC's Jurisdictional Challenge on August 20, 2018. It argues that CMS failed to use "appropriate data" in calculating Factor 3 for its FY 2016 UCC DSH payment as required by § 1886(r) of the Social Security Act because its own policy required that data be used from FY 2012 unless that cost report is unavailable or is less than a full 12-month

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[4] *Id.* at 2-3.
[5] *Id.*
[6] *Id.* (citing 78 Fed. Reg. 61191, 61195 (Oct. 3, 2013)).
[7] *Id.* at 2-3. *See also* 79 Fed. Reg. 49853.
[8] Medicare Administrative Contractor's Jurisdictional Challenge at 2 (Aug. 1, 2018).

year, and then it would use the longer of the 2012 or 2011 cost reports.[9] The Provider insists that it is not challenging the estimates made or time period selected in calculating Factor 3, but rather CMS' failure to follow its own policy in calculating its Medicaid-eligible days.[10] Finally, Provider states that CMS has acted *ultra vires* by counting patient days under Part C as "days entitled to benefits under Part A" in calculating its SSI ratio, contrary to the holding in *Allina*.[11]

Relevant Law and Analysis:

Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[12]
(B) Any period selected by the Secretary for such purposes.

Interpretation of Bar on Administrative Review

Tampa General v. Sec'y of HHS

In *Tampa General*,[13] the D.C. Circuit Court upheld the D.C. District Court's decision[14] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

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[9] Provider's Jurisdictional Response at 1 (citing 80 Fed. Reg. at 49529).
[10] *Id.* at 4.
[11] *Id.* at 2, 6.
[12] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[13] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[14] 89 F. Supp. 3d 121 (D.D.C. 2015).

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[15] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[16]

The District Court went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[17]

DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court addressed the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar*.[18] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The court disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[19] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that the court had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, it found the same relationship existed with regard to the methodology used to generate the estimates.[20]

Scranton Quincy Hosp. Co. v. Azar

Recently, however, in *Scranton Quincy Hosp. Co. v. Azar*,[21] the District Court for the District of Columbia considered a similar challenge and held that administrative review was precluded. In *Scranton*, Providers were challenging how the Secretary determined the amount of uncompensated

[15] 830 F.3d 515, 517.
[16] *Id.* at 519.
[17] *Id.* at 521-22.
[18] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[19] *Id.* at 506.
[20] *Id.* at 507.
[21] No. 18-32310 (ABJ) (consolidated 19-cv-1602), 2021 WL 65449 (D.D.C. Jan. 7, 2021) ("*Scranton*").

care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[22] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[23] Since the Providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[24] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[25]

In *Scranton*, the Providers argued that, unlike the Providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[26]

Finally, and perhaps most importantly, the court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[27] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[28] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated

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[22] *Id.* at *3.
[23] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[24] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[25] *Id.*
[26] *Id.* at *9.
[27] *Id.* at *10.
[28] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).

> powers and contrary to a specific prohibition in the statute that is clear and mandatory.[29]

The court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[30] The court ultimately upheld the Board's decision that it lacked jurisdiction to consider the Providers' appeals.

Announced Methodology for Factor 3 Calculation

When the Secretary began implementing the Uncompensated Care payments ahead of FY 2014, the Secretary proposed to estimate Factor 3 values based on the most recently available full year cost report data with respect to a federal fiscal year. For FY 2014, the Secretary used data from the 2010/2011 cost reports to estimate Factor 3.[31] For FY 2015, the Secretary maintained this approach and estimated the values for Factor 3 calculations based on the 2011/2012 cost reports, using 2012 unless that cost report was unavailable or reflected less than a full 12-month year, in which case the cost report from 2012 or 2011 that was closest to being a full 12-month cost report was used.[32] For FY 2016, the Secretary opted to use more recently updated data from the same 2012 or 2011 cost reports, noting that more recent cost reports may be available, but that these FYs would be more accurate since they had continued to be updated.[33]

Board Decision:

With regard to any argument that the Secretary could have used more accurate or recent data to calculate any portion of Provider's 2016 Uncompensated Care payments, the Board finds that the same findings from *Tampa General* and *DCH v. Azar* are applicable. The Provider is challenging the inclusion and/or exclusion of certain days and/or data in the estimates used by the Secretary, as well as the use of a stub-period cost report. The Board finds in challenging data included or excluded in calculating its Factor 3 values, the Provider is seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board finds in essence, the Provider is challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well. Furthermore, in challenging the Medicare Contractor's use of a stub-period cost report covering one time period, rather than a twelve-month cost report covering a different period, the Provider is challenging the "period selected by the Secretary" used in creating those estimates, which is also barred from review.

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[29] *Id.* (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[30] *Id.* at *11 (quoting *DCH v. Azar*, 925 F.3d at 509).
[31] 78 Fed. Reg. 50495, 50638 (Aug. 19, 2013).
[32] 79 Fed. Reg. 49853, 50018-50019 (Aug. 22, 2014).
[33] 80 Fed. Reg. 49325, 49528 (Aug. 17, 2015).

Likewise, with regard to the argument that the period used by the MAC was incorrect and in conflict with CMS' stated policy, the Board finds that it does not have jurisdiction to review this. While the Provider is not challenging any "estimate" or "period" which was *actually* chosen by the Secretary to calculate its 2016 Uncompensated Care payments, but rather the Medicare Contractor's alleged deviation from CMS' stated policy for making the calculation, the D.C. District Court held in *Scranton* that such a challenge is still barred from review, succinctly stating that any argument "that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[34]

Accordingly, the Board dismisses the DSH UCC payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In making this finding, the Board notes that its decision is consistent with the D.C. Circuit's decision in *Tampa General* and *DCH v. Azar* and that these decisions are controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[35]

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

Board Members Participating:	For the Board:
Clayton J. Nix, Esq. Gregory H. Ziegler, CPA Robert A. Evarts, Esq. Susan A. Turner, Esq. Kevin D. Smith, CPA	3/16/2021 X Clayton J. Nix Clayton J. Nix, Esq. Chair Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Laurie Polson, Palmetto GBA c/o National Government Services, Inc. (J-M)

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[34] *Scranton* at *10.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Determination of Groups filed from SSI Realignment Determinations***
Cleveland Clinic Fdn. CY 2007 DSH/SSI Percentage CIRP Group
Case No. 20-1514GC

Cleveland Clinic Fdn. CY 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
Case No. 20-1516GC

Cleveland Clinic Fdn. CY 2007 DSH Medicaid Fraction Dual Eligible Days CIRP Group
Case No. 20-1518GC

Dear Ms. Goron and Ms. Cummings:

The Provider Reimbursement Review Board ("Board") has reviewed the three (3) above-referenced common issue related party ("CIRP") group appeals in relation to three (3) participants. Specifically, these 3 CIRP group appeals each include the same 3 Providers as participants, all of which filed from Amended Notices of Amount of Program Reimbursement (RNPRs).[1] The background of the 3 CIRP groups, the pertinent facts related to the 3 participants in each and the jurisdictional decision of the Board, are set forth below.

Background of Groups:

On April 1, 2020, Healthcare Reimbursement Services, Inc. ("HRS") filed the subject group appeals with the Provider Reimbursement Review Board ("Board"). The group issue statements characterized the issues as follows:[2]

For the **SSI Percentage Group (Case No. 20-1514GC)**:

> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH") /Supplemental Security ("SSI") percentage, and whether CMS should be required to reclaculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand

[1] Hereafter, the Amended Notice of Amount of Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[2] Group Appeal Issue Statements (April 1, 2020).

> the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

For the **SSI Fraction Dual Eligible Days (Case No. 20-1516GC)**:

> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be excluded from the SSI or Medicare fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC's should have excluded from the SSI or Medicare fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make payment.

For the **Medicaid Fraction Dual Eligible Days (Case No. 20-1518GC)**:

> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC's should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make payment.

As previously noted, the groups include the same 3 Providers and all appealed from RNPRs.[3]

A. *Background on Participant #1 – South Pointe Hospital (Prov. No. 36-0144)*[4]

On August 14, 2019, the Medicare Contractor sent a Notice of Reopening of Cost Report for the cost report at issue for South Pointe Hospital. The RNPR for South Pointe Hospital was issued on October 2, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[5]

B. *Background on Participant #2 – Euclid Hospital (Prov. No. 36-0082)*

On October 16, 2015, the Medicare Contractor sent a Notice of Intent to Reopen the Cost Report for the cost report at issue for Euclid Hospital (*which also references participants 1 and 3*). This reopening notice states that the cost report was reopened solely for the following issue:

[3] The same three participants were also included in Case No. 20-1517GC for the DSH Medicaid Fraction Medicare Managed Care Part C Days issue. That Board found that the participants in the group did not have a right to appeal the RNPRs at issue pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b). The case was dismissed on September 24, 2020.

[4] South Point was the originating participant in used to form the groups.

[5] South Pointe's Audit Adjustment Report included in Group Appeal Request (April 1, 2020).

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 10/16/2015.[6]

The RNPR for Euclid Hospital was issued on October 2, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[7] HRS added Euclid Hospital to the three groups on April 2, 2020.

C. Background on Participant #3 – Cleveland Clinic (36-0180)

On October 16, 2015, the Medicare Contractor sent a Notice of Intent to Reopen the Cost Report for the cost report at issue for Cleveland Clinic. This reopening notice states that the cost report was reopened solely for the following issue:

> To update SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42CFR 412.106(b)(3) and the provider's request received 10/16/2015[8]

The RNPR for Cleveland Clinic was issued on October 2, 2019. The RNPR included adjustments "to update the SSI% and payment factor in accordance with CMS' SSI realignment calculation."[9] HRS added Cleveland Clinic to the three groups on April 6, 2020.

Board Determination

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

Relevant Regulations – RNPRs

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

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

[6] Euclid's Notice of Intent to Reopen Cost Report included in Direct Add Request (April 2, 2020).
[7] Euclid's Audit Adjustment Report included in Direct Add Request (April 2, 2020).
[8] Cleveland's Notice of Intent to Reopen Cost Report included in Direct Add Request (April 6, 2020).
[9] Cleveland's Audit Adjustment Report included in Direct Add Request (April 6, 2020).

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

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

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

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **<u>Exception</u>**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of

> receipt by the provider of the final contractor or Secretary determination.[10]

The Board finds that it does not have jurisdiction over the SSI Percentage, SSI Fraction Dual Eligible Days and Medicaid Fraction Dual Eligible Days issues for **South Pointe Hospital, Euclid Hospital and Cleveland Clinic,** *as participants in these three groups*, all of which were appealed from RNPRs.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[11] The reopening for these group participants were issued as a result of the Providers' requests to realign their SSI percentages from the federal fiscal year end to the individual cost reporting fiscal year end.

The audit adjustments associated with the RNPRs under appeal for the three group issues clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the providers' respective fiscal year. More specifically, the determination was only being reopened to include the realigned SSI percentages where the SSI percentages were realigned from the federal fiscal year to the provider's fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[12] In other words, the determinations were only being reopened to include the realigned SSI percentages and CMS' realignment process (as described in the Federal Register) does ***not*** entail re-running of the data matching process that the Provider is trying to appeal (much less change any Part A days in the underlying month-by-month data).[13] Since the only matters specifically revised in the RNPRs were adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, the Board does not have jurisdiction over **South Pointe**

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[10] (Emphasis added.)
[11] 42 C.F.R. § 405.1889(b)(1).
[12] 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). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).
[13] *See supra* note 12.

Hospital, Euclid Hospital and Cleveland Clinic because, pursuant to 42 C.F.R. § 405.1889(b) and § 405.1835(a)(1), they have no right to appeal the RNPRs for these 3 issues. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[14] As there are no remaining participants in Case Nos. 20-1514GC, 20-1516GC and 20-1518GC, the Board hereby dismisses the groups and removes them from the Board's docket.

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

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

For the Board:

3/17/2021

X Clayton J. Nix

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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John Bloom
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RE: ***Jurisdictional Determination***
Adventist Medical Center (Prov. No. 38-0060)
FYE 12/31/2014
Case No. 20-1835

Dear Ms. Bhatnagar and Mr. Bloom,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Representative's February 23, 2021 requests for transfer of the two issues in the subject appeal to common issue related party ("CIRP") groups. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On February 15, 2019, Toyon Associates, Inc. ("Toyon") filed a Reopening Request for the Provider. In its request, Toyon indicates that the provider is requesting ". . . a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year."

The Medicare Contractor ("MAC") issued a Notice of Reopening on June 25, 2019, in which it advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on data from the hospital's actual cost reporting period rather than the fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio."

The Notice of Amount of Corrected Program Reimbursement[1] (Revised NPR ("RNPR")) on January 2, 2020.

Toyon Associates, Inc. ("Toyon") filed an individual appeal of the RNPR with the Board on June 30, 2020. The appeal included two issues:

DSH Accuracy of CMS Developed SSI Ratio ("SSI Accuracy")
DSH Inclusion of Medicare Part C Days in the SSI Ratio ("SSI Fr. Part C Days")

[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").

The Provider referenced Audit Adjustment Nos. 1, 2, and 4 for both issues. Audit Adjustment No. 1 refers to completed cost report forms; Adjustment No. 2 refers to corrected mathematical flow through errors in cost report forms and Adjustment No. 4 adjusted the SSI Percentage and DSH amount.

On February 23, 2021, Toyon requested the transfer of the two issues in the individual appeal to the following CIRP groups:

Case No.	***Group***
18-1723GC	Adventist Health CY 2014 Inclusion of Part C Days in SSI Ratio CIRP
18-1726GC	Adventist Health CY 2014 Accuracy of CMS Developed SSI Ratio CIRP

On the same date, Toyon requested the closure of the individual case as there were no remaining issues.

<u>Board Determination</u>

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

<u>Relevant Regulations – RNPRs</u>

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

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

Additionally, 42 C.F.R. § 405.1889 (2018)[2] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the

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

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

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[3]

The Board finds that it does not have jurisdiction over the SSI Accuracy and SSI Fr. Part C Days issues in this individual appeal that filed from a revised NPR because the revised NPR was issued as a result of the Provider' SSI Realignment request, and did not adjust either issue. As a

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[3] (Emphasis added.)

result, the provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. The audit adjustments (#1, #2 and #4) associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. More specifically, the determination was only being reopened to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the provider's fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[5] In other words, the determinations were only being reopened to include the realigned SSI percentages and CMS' realignement process (as described in the Federal Register) does ***not*** entail re-running of the data matching process that the Provider is trying to appeal (much less revise any of the Part C days included in the underlying month-by-month data).[6] Since the only matters specifically revised in the revised NPR was the adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, the Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the SSI Accuracy and SSI Fr. Part C Days issues. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[7]

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[4] 42 C.F.R. § 405.1889(b)(1).

[5] 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). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] *See supra* note 5.

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

In conclusion, the Board ***dismisses*** the SSI Accuracy and SSI Fr. Part C Days issues from Case No. 20-1835 as the Provider does not have the right to appeal the RNPR at issue for these two issues.[8] Further, the Board necessarily ***denies*** the Provider's requests to transfer these issues to Case Nos. 18-1723GC and 18-1726GC. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 20-1835 and removes it from the Board's docket.

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

Board Members Participating:

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

FOR THE BOARD:

3/17/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dylan Chinea, Toyon Associates, Inc.

[8] Moreover, had the Board not dismissed the Part C issue, the Board may have had alternative grounds to dismiss the Part C Days issue as the Board has concerns that Adventist Medical Center may be participating in another Adventist Part C Day CIRP group(s) based on the appeal of another determination(s). This would be prohibited under Board Rule 4.6. In this regard, the Board takes administrative notice that there are multiple 2014 Adventist Part C day CIRP groups (i.e., Case No. 18-1723GC is only one of those). The Board further notes that multiple CIRP groups for the same organization for the same issue and year is prohibited by 42 C.F.R. §§ 405.1837(b)(1). *See also* 42 C.F.R. § 405.1837(e)(1) ("When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal."). The Board will address the improper duplication of CIRP groups under separate cover.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Lisa Ellis
Director –Client Services
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
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Lorraine Frewert
Appeals Coordinator, J-E Provider Audit
Noridian Healthcare Solutions c/o Cahaba
Safeguard Administrators (J-E)
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RE: ***Jurisdictional Determination***
St. Joseph Hospital (05-0069) FYE 06/30/2015, Case No. 20-1989

Dear Ms. Ellis and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

Toyon Associates, Inc. ("Toyon") filed a Reopening Request for the Provider on May 29, 2019. In its request, Toyon indicates that the provider is requesting ". . . a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year."

The MAC issued a Notice of Reopening, on August 16, 2019, in which it advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio."

The Notice of Amount of Corrected Reimbursement (RNPR) was issued on February 26, 2020.[1]

Toyon filed an individual appeal for the Provider on August 19, 2020, to which the Board assigned Case No. 20-1989. The three issues in the appeal are:

DSH Accuracy of CMS Developed SSI Ratio (SSI Accuracy)
DSH Inclusion of Medicare Part C Days in the SSI Ratio (SSI Fr. Part C days)
DSH Inclusion of Medicare Unpaid Part A Days in SSI Ratio (SSI Fr. Part A days)

[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").

Toyon referenced audit adjustment # 4 for all three issues. This audit adjustment was made "[t]o adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment."

Board Determination

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

Relevant Regulations – RNPRs

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

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

Additionally, 42 C.F.R. § 405.1889 (2018)[2] explains the effect of a cost report revision:

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

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

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[3]

The Board finds that it does not have jurisdiction over three issues in this individual appeal, which was filed from a RNPR.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. The audit adjustment #4 associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. More specifically, the determination was only being reopened to include the realigned SSI percentages where the SSI percentages were realigned from the federal fiscal year to the provider's fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in

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

order to effectuate a realignment.[5] In other words, the determinations were only being reopened to include the realigned SSI percentages and CMS' realignement process (as described in the Federal Register) does ***not*** entail re-running of the data matching process that the Provider is trying to appeal (much less change any Part A or Part C days in the underlying month-by-month data).[6] Since the only matters specifically revised in the revised NPR was adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, the Board does not have jurisdiction over the three issues in the subject individual appeal.

Finally, the Board notes that St. Joseph's Hospital (Prov. No. 05-0069) already has another individual appeal pending for FYE 6/30/2015 under Case No. 18-1092 based on the original NPR dated September 26, 2017. Significantly, Case No. 18-1092 has pending these very same three issues (among other issues). ***The Board admonishes Toyon for pursuing the same issue for the same fiscal year in two separate cases and needlessly wasting Board resources.*** *This is a violation of Board Rule 4.6.2 entitled "Same Issue from Multiple Determinations" instructing:*

> Appeals of the same issue from distinct determination *must be pursued* in a ***single*** appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals.

The Board reminds Toyon that it has a responsibility of both managing and maintaining an accurate inventory of client appeals and ensuring no duplicate appeals (for same issue for the same fiscal year) are pursued in separate cases.

In conclusion, the Board dismisses the SSI Accuracy, SSI Fr. Part C days and SSI Fr. Part A days issues from Case No. 20-1989 as the Provider does not have the right to appeal the RNPR at

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[5] 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). However, CMS does not utilize the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).
[6] *See supra* note 5.

issue under 42 C.F.R. § 405.1889. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 40531889(b).[7] As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 20-1989 and removes it from the Board's docket.

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

Board Members Participating:

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

FOR THE BOARD:

3/17/2021

X Clayton J. Nix

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

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

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[7] *See, e.g., St. Mary's of Mich.v.Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020): *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. Of OK v. Shalala*, 25 F.3d 614 (D.C. Cir. 1994).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Determination***
Alta Bates Medical Center (05-0305), FYE 12/31/2012, PRRB Case No. 20-2086

Dear Ms. Giberti and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Representative's January 4, 2021 requests to transfer all six issues to common issue related party ("CIRP") groups. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

Toyon Associates, Inc. ("Toyon") requested a reopening of the Provider's cost report in a letter dated July 24, 2019. The reopening specifically states that the Provider ". . . requests a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year. The Provider's cost reporting period is 1/1/2012 t0 12/31/2012."

The Notice of Reopening was issued on September 5, 2019, in which it advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio."

The Notice of Amount of Corrected Reimbursement (RNPR) was issued on March 31, 2020.[1]

The individual appeal from the RNPR was filed by Sutter Health ("Sutter") on September 17, 2020, to which the Board assigned Case No. 20-2086.[2] The RNPR appeal included six issues:

DSH SSI Ratio – Inaccurate Data (SSI Accuracy)
DSH SSI Ratio Dual Eligible Part C Days (SSI Fr. Part C days)
DSH SSI Ratio Dual Eligible Part A Days (SSI Fr. Part A days)

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[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[2] Sutter Health filed a separate appeal for the RNPR rather than using the "Add Determination" case action to add it to the pending appeal for the Provider's FYE 12/31/2012 pending NPR based appeal (Case No. 19-2094).

DSH SSI Ratio MMA Section 951 (SSI MMA Section 951)
DSH Medicaid Ratio Dual Eligible Part C Days (M'caid Fr. Part C days)
Medicare DSH Medicaid Ratio Dual Eligible Part A Days (M'caid Fr. Part A days)

The Provider referenced audit adjustment # 4 for all six issues. Adjustment #4 was issued "[t]o adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment."

On January 4, 2021, Sutter requested the following transfers from the RNPR appeal, Case No. 20-1835, to CIRP groups:

Issue	Case No.
SSI Accuracy	18-0294GC
SSI Fr. Part C days	18-0147GC
SSI Fr. Part A days	18-0290GC
SSI MMA Section 951	18-0143GC
M'caid Fr. Part C days	18-0146GC
M'caid Fr. Part A days	18-0148GC

Board Determination

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

Relevant Regulations – RNPRs

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

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the

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

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[3]

The Board finds that it does not have jurisdiction over the six issues in this individual appeal filed from the revised NPR because the revised NPR was issued as a result of the Provider' SSI Realignment request, and did not specifically adjust these issues. As a result, the provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[3] (Emphasis added.)

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. The audit adjustment (#4) associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. More specifically, the determination was only being reopened to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the provider's fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[5] In other words, the determinations were only being reopened to include the realigned SSI percentages and CMS' realignement process (as described in the Federal Register) does ***not*** entail re-running of the data matching process that the Provider is trying to appeal (much less revise any of the Part A or Part C days included in the underlying month-by-month data).[6] Since the only matter specifically revised in the revised NPR was the adjustments related to realigning the SSI percentage from federal fiscal year to the provider fiscal year, the Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the the SSI Accuracy, SSI Fr. Part C days, SSI Fr. Part A days, SSI MMA Section 951, M'caid Fr. Part C days and M'caid Fr. Part A days issues in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[7]

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[4] 42 C.F.R. § 405.1889(b)(1).

[5] 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). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] *See supra* note 5.

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

In addition, the Board directs the Representative's attention to Board Rule 6.3, which gives guidance on multiple determinations appealed by a Provider for the same fiscal year end. The Rule states:

> **6.3 Adding a New Determination to an Individual Case**
>
> **6.3.1 Request and Supporting Documentation**
>
> For individual appeals, an appeal may be for only one cost reporting period. *If multiple final determinations were issued* ***on different dates*** *for the cost reporting period being appealed* (e.g., NPR, revised NPRs, exception request denials, etc.), *providers* ***must*** *timely request to add the subsequent determination to its pending appeal for that cost reporting period*. Reference Model Form A – Individual Appeal Request (Appendix A) for all required data fields and supporting documentation.[8]

Similarly, Board Rule 4.6 prohibits "Duplicate Filings":

> **4.6 No Duplicate Filings**
>
> **4.6.1 No Duplicate Filings Same Issue from One Determination**
>
> A provider may not appeal an issue from a single final determination in more than one appeal.
>
> **4.6.2 Same Issue from Multiple Determinations**
>
> Appeals of the same issue from distinct determinations must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals.
>
> **4.6.3 Issue Previously Dismissed or Withdrawn**
>
> Once an issue is dismissed or withdrawn, the issue may not be appealed in any other case.

Accordingly, in this instance, the appeal of the RNPR *should have been added to the Provider's pending individual appeal under Case No. 19-2094 which, in addition to others, contains the* ***same*** *six issues addressed herein.* ***The Board directs the Representative to review Board Rules 4.6 and 6.3 and come into compliance with them to ensure duplicate individual appeals are not filed***.

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[8] Board Rules. (Aug. 29, 2018)

In conclusion, the Board ***dismisses*** the six issues appealed from the RNPR in Case No. 20-2086 as the Provider does not have the right to appeal the RNPR at issue for these issues. Further, the Board necessarily ***denies*** the Provider's previous requests to transfer these issues to Case Nos. 18-0294GC, 18-0147GC, 18-0290GC, 18-0143GC, 18-0146GC and 18-0148GC, respectively. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 20-2086 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/19/2021

X Clayton J. Nix

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

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

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Via Electronic Delivery

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RE: ***Jurisdictional Determination***
Enloe Medical Center (05-0039), FYE 06/30/2011, PRRB Case No. 20-2117

Dear Ms. Ellis and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

The Provider filed a Reopening Request on March 4, 2015. In its request, the Provider requests ". . . a recalculation of its Hospital SSI ratio for purposes of aligning it with the Hospital's fiscal year ended 6/30/2011."

The MAC issued a Notice of Reopening, on December 7, 2016, in which it advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio."

The Notice of Amount of Corrected Reimbursement (RNPR) was issued on March 31, 2020.[1]

The individual appeal for the Provider was filed by Toyon on September 22, 2020, to which the Board assigned Case No. 20-2117. The two issues in the appeal are:

- DSH Accuracy of CMS Developed SSI Ratio (SSI Accuracy)
- DSH Inclusion of Medicare Part C Days in the SSI Ratio (SSI Fr. Part C days)

The Provider referenced audit adjustment # 4 for both issues. Audit Adjustment # 4 indicates it was issued "[t]o adjust the SSI% and the Disproportionate Share Amount based on the latest

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[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").

CMS Letter of SSI% Realignment." The SSI % changed from 7.84 to 8.90 and the DSH was adjusted from 11.76 to 12.64.

Board Determination

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

Relevant Regulations – RNPRs

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

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

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

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

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[2]

The Board finds that it does not have jurisdiction over the two issues in this individual case, which was filed from the revised NPR because the revised NPR was issued as a result of the Provider' SSI Realignment request, and did not specifically adjust the SSI Accuracy and SSI Fr. Part C days issues. As a result, the provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. The audit adjustment (#4) associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. More specifically, the determination was only being reopened to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the provider's fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[4] In other words, the determinations were only being reopened to

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[2] (Emphasis added.)
[3] 42 C.F.R. § 405.1889(b)(1).
[4] 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). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the

include the realigned SSI percentage and CMS' realignement process (as described in the Federal Register) does ***not*** entail re-running of the data matching process that the Provider is trying to appeal (much less revise any of the Part C days included in the underlying month-by-month data).[5] Since the only matters specifically revised in the revised NPR was the adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, the Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the SSI Accuracy and SSI Fr. Part C Days issues.

In conclusion, the Board ***dismisses*** the SSI Accuracy and SSI Fr. Part C days issues from Case No. 20-2117 as the Provider does not have the right to appeal the RNPR at issue under 42 C.F.R. § 405.1889. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[6] As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 20-2117 and removes it from the Board's docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
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Robert A. Evarts, Esq.
Susan A. Turner, Esq.
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For the Board:

3/19/2021

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Chair
Signed by: Clayton J. Nix -A

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underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[5] *See supra* note 5.

[6] *See, e.g., St. Mary's of Mich.v.Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020): *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. Of OK v. Shalala*, 25 F.3d 614 (D.C. Cir. 1994).

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Via Electronic Delivery

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RE: ***Jurisdictional Determination***
Mission Regional Medical Center (05-0567), FYE 06/30/2009, PRRB Case No. 19-2372

Dear Ms. Giberti and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare Contractor's June 2, 2020 jurisdictional challenge. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

The Medicare Contractor forwarded the Provider's August 25, 2014 Request for Reopening to CMS on September 10, 2014. The cover letter indicates the Provider had requested to have CMS recalculate their SSI percentage based on their cost-reporting year July 1, 2008 to June 30, 2009.

The Notice of Reopening was issued on December 8, 2016, in which the Medicare Contractor advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio."

The Notice of Amount of Corrected Reimbursement (RNPR) was issued on February 12, 2019.[1]

The individual appeal for the Provider was filed by Toyon Associates, Inc. ("Toyon") on August 8, 2019, to which the Board assigned Case No. 19-2372. The appeal included two issues:

- DSH Accuracy of CMS Developed SSI Ratio (SSI Accuracy)
- DSH Inclusion of Medicare Part C Days in the SSI Ratio (SSI Fr. Part C days)

[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").

For both issues, the Provider referenced audit adjustment # 1 and #4. Both adjustments indicate they were issued "[t]o include the SSI as calculated by CMS and to revise the DSH percentage for proper calculation of the DSH adjustment payment."

On February 25, 2020, Toyon requested the transfer of the SSI Fr. Part C days issue to Case No. 20-1262G. The Provider was subsequently dismissed from the group, in a determination dated October 30, 2020.

On June 2, 2020, the MAC challenged the Board's jurisdiction over the remaining issue in the individual appeal involving the SSI Accuracy, because the issue was not adjusted on the RNPR.

Board Determination

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

Relevant Regulations – RNPRs

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

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

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

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

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

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[2]

The Board finds that it does not have jurisdiction over the remaining SSI Accuracy issue in this individual appeal, which was filed from a RNPR.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. The audit adjustments (#1 and #4)

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

associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. More specifically, the determination was only being reopened to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the provider's fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[4] In other words, the determinations were only being reopened to include the realigned SSI percentages and CMS' realignement process (as described in the Federal Register) does ***not*** entail re-running of the data matching process that the Provider is trying to appeal.[5] Moreover, the provider "must accept the resulting DSH percentage for that year.[6] Since the only matters specifically revised in the revised NPR was the adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, the Provider does not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the remaining issue in this appeal – the SSI Accuracy issue.

In conclusion, the Board ***dismisses*** the SSI Accuracy issue from Case No.19-2372 as the Provider does not have the right to appeal the RNPR at issue under 42 C.F.R. § 405.1889. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 40531889(b).[7]

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[4] 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). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).
[5] *See supra* note 4.
[6] 70 Fed. Reg. at 47439 (*see* quote in *supra* note 4). *See also* 42 C.F.R. §412.106(b)(3) (stating "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.").
[7] *See, e.g., St. Mary's of Mich.v.Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020): *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. Of OK v. Shalala*, 25 F.3d 614 (D.C. Cir. 1994).

As there are no remaining issues in the individual appeal, the Board hereby closes Case No.19-2372 and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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FOR THE BOARD:

3/22/2021

X Clayton J. Nix

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Chair
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Via Electronic Delivery

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RE: ***Jurisdictional Decision***
Hall Render FFY 2020 Uncompensated Care Payments Groups
FYE 2020
Case Nos. 20-1006G, 20-0950GC, 20-0954GC, 20-0996GC, 20-1051GC, 20-0990GC

Dear Ms. O'Brien Griffin,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced six (6) group appeals. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The Providers are appealing from the Federal Register published on August 16, 2019.[1] The issue being appealed is a challenge to the Disproportionate Share Hospital ("DSH") payment for Uncompensated Care Costs ("UCC"). Specifically, Providers are appealing the Medicare Contractor's alleged procedurally unlawful policies surrounding audits of their S-10 worksheets for CY 2015, which impacts their FY 2020 UCC DSH payments. They claim that their S-10's were arbitrarily audited without issuing adequate UCC reporting guidelines or going thorough adequate notice and comment requirements. They state that audits of hospitals' S-10's were inconsistent and unfair.

The Providers raise several arguments about the accuracy of the S-10 data used and the methodology for auditing those worksheets. While the Providers acknowledge that the estimates used by the Secretary for the UCC DSH payment are not subject to review, they claim "when CMS imposes a policy that impacts providers' payments in a manner that violates notice and comment their actions are subject to review" based on the U.S. Supreme Court's 2019 decision in *Allina*.[2] Providers continue by claiming the skewed policy used in auditing different hospitals' S-10 worksheets is unlawful and ultra vires, and that a statutory bar on administrative and judicial review does not extend to these types of actions, citing to the 2019 decision of the Connecticut District Court in *Yale New Haven v. Azar* ("*Yale*")[3] for support. Finally, Providers

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[1] 84 Fed. Reg. 42044 (Aug. 16, 2019).
[2] *Azar v. Allina Health Servs*, 139 S. Ct. 184, 1809 (2019).
[3] 409 F.Supp.3d 3 (D. Conn. 2019).

reiterate that, similar to the policies at issue in *Allina*, the policies governing the S-10 audits were required to undergo notice and comment rulemaking pursuant to 42 U.S.C. § 1395hh(a)(2) because it affects benefits, payments, or eligibility.[4]

The Providers' Representative filed a request for Expedited Judicial Review ("EJR") for six group cases on March 4, 2021. The EJR request elaborates on the arguments made in the Group Issue Statement.[5] It provides a regulatory history of the DSH statute[6] and the chronology of the Worksheet S-10 Audit rollout, emphasizing that they were done in an unfair way that lacked transparency, consistency, and advance notice.[7] Since these audits were so flawed, the Providers argue that the S-10 disallowances used by CMS to compute their FFY 2020 UCC payments were improper.[8]

The Providers argue that, notwithstanding the statutory bar on administrative review, the Board has jurisdiction over this issue because it is a specific challenge to a procedurally invalid policy that did not undergo proper notice and comment rulemaking.[9] They claim that, in *Yale*, this precise claim was the only one permitted by the court – a challenge to the underlying procedure which established a policy. Since the Board has jurisdiction, and since the Board lacks the authority to render the CMS audit policy invalid, the Providers are requesting the Board grant EJR pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842.

Relevant Law and Analysis:

A. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[10]

(B) Any period selected by the Secretary for such purposes.

[4] Group Issue Statement.
[5] EJR Request at 1-3, 10-16.
[6] *Id.* at 4-6.
[7] *Id.* at 7-10.
[8] *Id.* at 8.
[9] *Id.* at 10-13.
[10] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

B. Interpretation of the Statutory Bar on Administrative Review

1. Tampa General v. Sec'y of HHS

In *Tampa General*,[11] the D.C. Circuit Court upheld the D.C. District Court's decision[12] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. District Court found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the provider was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[13] The Court also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[14]

The D.C. Circuit Court went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[15] In summary, the D.C. Circuit Court found that "[the provider] is simply trying to undo the Secretary's estimate of the hospital's uncompensated care by recasting its challenged to the Secretary's choice of data as an attack on the general rules leading to her estimate."[16]

2. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court addressed the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar*.[17] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the

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[11] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[12] 89 F. Supp. 3d 121 (D.D.C. 2015).
[13] 830 F.3d 515, 517.
[14] *Id.* at 519.
[15] *Id.* at 521-22 (citation omitted).
[16] *Id.*
[17] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").

Secretary to calculate Factor 3 of the DSH payment. Indeed, the provider contended that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit Court disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[18] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit again found the same relationship existed with regard to the methodology used to generate the estimates.[19]

3. Yale New Haven Hosp. v. Azar

The Connecticut District Court subsequently considered the bar on review of UCC DSH payments in *Yale New Haven Hosp. v. Azar* ("*Yale*").[20] There, the Court dismissed all of the providers' counts in their federal complaint except one. Those that clearly sought to "undo the Secretary's estimate of its uncompensated care by recasting its challenge to that estimate as an attack on the underlying methodology" were dismissed.[21] The remaining count, the Court held, did "not challenge the Secretary's estimate of [the provider's] DSH payment, any of the underlying data, or the Secretary's choice of such data. Instead, it [was] a challenge to the procedure by which the Secretary established the" issue under appeal. The Court noted that it was a close call, but there was no bar on review of "the *promulgation* of the Secretary's rules and policies, separate from the *substance* of any such rules or policies or the determination of its estimates based on the substance of those rules or policies."[22]

4. Scranton Quincy Hosp. Co. v. Azar

Recently, however, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[23] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[24] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a

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[18] *Id.* at 506.
[19] *Id.* at 507.
[20] 409 F.Supp.3d 3 (D. Conn. 2019).
[21] *Id.* at 14 (quoting *DCH v. Azar* at 508).
[22] *Id.* at 15. The District Court for Connecticut later ruled that the UCC DSH payment rule at issue in that case (the Merger Hospital Policy), which is distinct from the Worksheet S-10 Audit policy at issue in this case, had not undergone sufficient notice and comment procedures. 457 F.Supp.3d 93, 111 (D. Conn. 2020). The court balanced different considerations in coming up with a remedy, and ultimately remanded the case to the Secretary without vacatur of the rule. *Id.* at 112.
[23] No. 18-32310 (ABJ) (consolidated 19-cv-1602), 2021 WL 65449 (D.D.C. Jan. 7, 2021) ("*Scranton*").
[24] *Id.* at *3.

period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[25] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[26] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[27]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[28]

Finally, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[29] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the Court found that the criteria in *Scranton* case were not met.[30] For review to be available in these circumstances, the Court noted that the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[31]

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[25] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[26] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[27] *Id.*
[28] *Id.* at *9.
[29] *Id.* at *10.
[30] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[31] *Id.* (quoting *DCH v. Azar*, 925 F.3d at 509-510).

The Court found that the preclusion of review for this issue was ***express***, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[32] The court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

<u>Board Decision:</u>

In the EJR request, the Providers characterize the issue in these 6 groups as follows:

> At CMS's request, the Medicare Administrative Contractors ("MACs") audited the Hospitals' FYE 2015 S-10 Worksheets. CMS required each MAC to audit the hospitals with the highest amounts of uncompensated care in their jurisdiction. CMS elected not to publish and allow the hospital industry to comment on any audit protocol, guidance, or instructions, if any, it distributed to the MACs. . . .
>
> The unpublished audit protocols, guidance, and/or instructions did not comply with the necessary public notice and comment requirement. Additionally, the results of the audits indicate that they were performed in an arbitrary and capricious fashion from hospital to hospital and MAC to MAC. . . .
>
> The CMS/MAC S-10 audits thus imposed a substantive legal standard that substantially impacted receipt of a federal benefit or program payment. Additionally, the audits were haphazard, arbitrary, capricious, and flawed.[33]

The Board finds that the issue presented in these cases is ultimately an attack on the underlying S-10 data used in calculating the Providers' Factor 3 values, framed as an attack on whether the methodologies adopted in obtaining that data are procedurally valid. The Board finds that this is, essentially, a direct attack on the methodologies themselves. An attack on these methodologies is precluded from review pursuant to the holding in *DCH v. Azar* interpreting and applying 42 U.S.C. § 1395ww(r)(3). By appealing the Federal Register which published the specific FFY 2020 UCC DSH payments amounts, the Providers are attempting to "undo a shielded determination" by attacking the general rules leading to DSH UCC estimates, which *Tampa General* held was precluded from review. Finally, the issue also fits the rationale from *Scranton*, which found review was precluded since the policies at issue here govern the method used and

[32] *Id.* at *11 (quoting *DCH v. Azar*, 925 F.3d at 509).
[33] EJR request at 2-3.

the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care payments.

Based on the above, the Board finds that, pursuant to 42 U.S.C. § 1395ww(r)(3), it does not have jurisdiction over the appeal and, to that end, must also deny EJR since jurisdiction is a prerequisite to a Board decision on EJR as explained at 42 C.F.R. § 405.1842(b)(1). In denying jurisdiction, the Board notes that the D.C. Circuit's decisions in *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[34]

Since the DSH UCC issue is the only issue presented in these group cases, the Board hereby closes the cases and removes them from its docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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Kevin D. Smith, CPA

For the Board:

3/22/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-8)
Judith Cummings, CGS Administrators (J-15)
Cecile Huggins, Palmetto GBA (J-J)
Danene Hartley, National Government Services, Inc. (J-6)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services
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Arcadia, CA 91006

RE: ***Request to Reinstate Participants and Amend EJR Determination***
15-0929GC QRS Providence 2012 SSI-Dual Eligible Days Group
Relating to previously-dismissed participants:
#2 Providence Little Company of Mary-San Pedro (Prov. No. 05-0078, FYE 12/31/12)
#3 Providence St. Joseph Medical Center (Prov. No. 05-0245, FYE 12/31/12)
#4 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/12)
#5 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/12)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Group Representative's December 24, 2020 and January 7, 2021 requests to reinstate the four (4) providers referenced-above into Case No. 15-0929GC. In addition, the Providers in this group appeal had filed a request for expedited judicial review ("EJR") for the above-referenced common issue related party ("CIRP") group appeal on March 13, 2020, and the Board issued a decision with respect to the remaining Providers in Case No. 15-0929GC on November 30, 2020.[1] *The Board hereby supplements its November 30, 2020 determination*, and set forth below is the Board's determination regarding the request to reinstate and grant EJR for the following previously dismissed participants:

#2 Providence Little Company of Mary-San Pedro (Prov. No. 05-0078, FYE 12/31/12);
#3 Providence St. Joseph Medical Center (Prov. No. 05-0245, FYE 12/31/12);
#4 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/12); and
#5 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/12).

Effect of COVID -19 on Board Operations and Staying of the 30-day Period to Respond to EJR Requests:

By letter dated April 4, 2020, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services ("CMS") required its personnel to

[1] The EJR also included a number of other case numbers. The Board has responded to the original request for EJR in those cases under separate cover.

telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On April 9, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e*., whether 'a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR." 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeal.

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on March 3, 2020, the Board did not receive the EJR request for the above-referenced appeal in its office until March 13, 2020, after the Board and its staff had begun to telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers submitted March 3, 2020. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

Reinstatement Requests

A. #3 Providence St. Joseph Medical Center (Prov. No. 05-0245, FYE 12/31/12)

In the case of #3 Providence St. Joseph Medical Center (Prov. No. 05-0245, FYE 12/31/12), the Group Representative failed to include proof of delivery of its hearing request in the jurisdictional documents accompanying the Schedule of Providers as required by Board Rule 21.3.2.[2] Instead, the Group Representative attached a notice that the package was assigned a shipping number and scheduled for shipment, but the notice failed to demonstrate that the package had, in fact, been delivered to the Board (much less that the package had actually been received and sent by the delivery service itself). Rule 21.3.2 requires that jurisdictional documentation accompanying the Schedule of Providers include proof of delivery of the hearing request under Tab B for each provider to establish the appeal was timely filed. Rule 21.3.2 states that when a Schedule of Providers is filed with the Board each Provider must include:

> A copy of the relevant pages from the initial appeal request (Model Form A or E) and the request to add an issue, if applicable (Model Form C), including the issue statement, or other written requests filed prior to the use of such Model Forms in which this issue was appealed for the first time. In addition, if the appeal was filed after August 21, 2008, include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS

[2] The Board's Rules are found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.

> tracking) for both the original appeal request and the addition of the issue.[3]

Consequently, the Board dismissed the Provider as part of the jurisdictional determination made in conjunction with the EJR decision in Case No. 15-0929GC issued on November 30, 2020.[4]

On January 7, 2021, the Group Representative asked that the appeal for #3 Providence St. Joseph Medical Center (Prov. No. 05-0245, FYE 12/31/12) be reinstated. In conjunction with this request, the Group Representative submitted a copy of the United Parcel Service proof of delivery for the hearing request. Since the Group Representative has submitted the required proof of timely filing, the Board hereby reopens Case No. 15-0929GC and reinstates #3 Providence St. Joseph Medical Center (provider no. 05-0245, FYE 12/31/12).

A. #2 Providence Little Company of Mary-San Pedro (Prov. No. 05-0078, FYE 12/31/12); #4 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/12); and #5 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/12).

On December 24, 2020, the Group Representative filed a request to reinstate the appeals of #2 Providence Little Company of Mary-San Pedro (provider no. 05-0078, FYE 12/31/12), #4 Providence Holy Cross Medical Center (provider no. 05-0278, FYE 12/31/12) and #5 Providence Little Company of Mary-Torrance (provider no. 05-0353, FYE 12/31/12). The three Providers each established an individual appeal and then requested transfer to a CIRP group. The Board concluded that the information included with the Schedule of Providers for these individual Providers was incomplete because the copy of Model Form A-Individual Appeal Request under Tab B of the jurisdictional documents was incomplete. The Providers failed to include the statement of the issue(s) from the Providers' respective original individual appeal requests. However, each of the Providers timely added the dual eligible days issue to their individual appeals using a Model Form C-Request to Add Issue(s) to an Individual Appeals.

In the December 24, 2020 reinstatement request, the Group Representative asserted that the statement of the issue was placed under Tab B, behind the proof of delivery for the original hearing request. Notwithstanding, the Group Representative furnished copies of the requested issue statements with the December 24, 2020 reinstatement request. In review, the Board identified the statement of the added issues[5] and the Board concludes that the Providers have complied with the requirements of Board Rule 21.3.2 which states the documents under Tab B must include:

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[3] The Board notes that this rule is consistent with 42 C.F.R. § 405.1837(a)(1) and (c) that require each provider demonstrate it satisfies individually the requirement for a Board hearing which includes the requirement that an appeal be timely filed with the Board.

[4] Jurisdiction over participants in a group appeal is a perquisite to granting a request for EJR. *See* 42 C.F.R. § 405.1842(a).

[5] *See* 42 U.S.C. § 405.1835(b) (Contents of request for a Board hearing on final contractor determination. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
(1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.

> A copy of the relevant pages from the initial appeal request (Model Form A or E) and the request to add an issue, if applicable (Model Form C), including the issue statement, or other written requests filed prior to the use of such Model Forms in which this issue was appealed for the first time. In addition, if the appeal was filed after August 21, 2008, include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue.

Consequently, the Board reinstates the appeals of #2 Providence Little Company of Mary-San Pedro (Prov. No. 05-0078, FYE 12/31/12), #4 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/12) and #5 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/12). The Board decision with respect to the four Providers' EJR request is set forth below.

EJR Decision

Issue in Dispute:

The group issue statement filed to establish this CIRP group is entitled "Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)" and it contains the following description of the issue:

> Whether patient days associated with Medicare Part A and Title XIX patients should be *excluded* from the SSI or ***Medicare*** fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have excluded from the SSI or ***Medicare*** fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.[6]

The group issue statement then provides the following "Statement of the Legal Basis":

> The Provider contends that the MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual

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(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
(i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).).

[6] (Emphasis added.)

> eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.
>
> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. *The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.*
>
> *It is the Provider's contention that these days must be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula.*[7]

The EJR request characterizes the group issue in this CIRP appeal as:

> Whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "*dual eligible*"), and for whom Medicare has not made payment for that inpatient stay (hereinafter referred to as *"noncovered days")* should be included in the Medicare fraction of the *Medicare* Disproportionate Share (DSH) adjustment, as alleged by the MAC [Medicare Administrative Contractor], or should be excluded *Medicare* fraction of the DSH adjustment, and instead included in the *Medicaid* fraction . . . .[8]

The EJR request specifies that the relief being requested is that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is

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[7] (Italics emphasis added and bold and underline emphasis in original.)
[8] Providers' EJR request at 2-3 (emphasis in original).

eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."[9]

Statutory and Regulatory Background: Medicare DSH Payment

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[10] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[11]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[12] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[13]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[14] 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.[15] The DPP is defined as the sum of two fractions expressed as percentages.[16] 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 . . . .[17]

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[9] *Id.* at 1.
[10] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[11] *Id.*
[12] *See* 42 U.S.C. § 1395ww(d)(5).
[13] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[14] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[15] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[16] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[17] (Emphasis added.)

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[18]

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.[19]

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.[20]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[21] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[22]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[23] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[24] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare

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[18] 42 C.F.R. § 412.106(b)(2)-(3).
[19] (Emphasis added.)
[20] 42 C.F.R. § 412.106(b)(4).
[21] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[22] *Id.*
[23] *Id.*
[24] *Id.*

fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[25]

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[26] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[27] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[28]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[29] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[30] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended.[31] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[32]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[33] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[34]

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[25] *Id.* at 27207-27208.
[26] *Id.* at 27207-08.
[27] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[28] 68 Fed. Reg. at 27208.
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[34] *Id.*

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[35]

In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[36]
>
> ****
>
> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation.*[37]

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[38] In order to effectuate this policy change, the FY 2005

[35] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[36] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[37] *Id.* at 49099 (emphasis added).
[38] *Id.*

IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[39] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that*—
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[40]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[41]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[42]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[43] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[44] The D.C. District Court concluded that the

[39] *See id.* at 49099, 49246.
[40] (Emphasis added.)
[41] (Emphasis added.)
[42] *Id.*
[43] 317 F. Supp. 3d 168 (D.D.C. 2018).
[44] *Id.* at 172.

Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[45] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[46] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[47] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[48] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[49] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[50]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[51] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[52] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[53] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate contest in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[54] and that the regulation is procedurally invalid.[55]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[56] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural

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[45] *Id.* at 190.
[46] *Id.* at 194.
[47] *See* 2019 WL 668282.
[48] 718 F.3d 914 (2013).
[49] 657 F.3d 1 (D.C. Cir. 2011).
[50] 718 F.3d at 920.
[51] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[52] *Id.* at 1141.
[53] *Id.*
[54] *Id. at 1162.*
[55] *Id. at 1163*
[56] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir., Oct. 20, 2020). It is unclear if the Secretary will petition the U.S. Supreme Court to review the Ninth Circuit's *Empire* decision.

rulemaking requirements of the APA.[57] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[58] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[59] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[60] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[61] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[62] Accordingly, the Ninth Circuit to the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force).

As of the date of this decision, the Secretary's position with respect to the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

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

The Providers contend that the non-covered patient, *i.e.*, days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make payment for their hospital stays because the patient's Medicare patient days were exhausted or because a third party made payment, should be excluded from the Medicare fraction of the DSH fraction. The Providers maintain *in their EJR request* that these non-covered patient days should be treated consistently: (1) they should be included in both the numerator and denominator of the SSI fraction; or (2) excluded from the numerator and denominator of the SSI fraction and then be recognized in the numerator of the Medicaid fraction.[63]

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[57] *Id.* at 884.
[58] *Id.* at 884.
[59] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[60] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[61] *Id.* at 886.
[62] *Id.*
[63] Providers' EJR Request at 2.

The Providers explain that the applicable regulations require that non-covered patient days be included in the Medicare fraction due to the change made to the regulations effective October 1, 2004. This was accomplished by the deletion of the word "covered" where it had previously appeared in the definition of the Medicare fraction in 42 C.F.R. § 412.106(b)(2)(i). As a result of this change, the regulation now requires the inclusion in the Medicare fraction of both exhausted benefit and Medicare secondary payment days associated with patient discharges occurring on or after October 1, 2004.

The Providers assert that the Secretary improperly promulgated the revision to § 412.106(b)(2)(i) as part of the FY 2005 IPPS Final Rule and that this revision should be vacated due to *procedural* violations of the Administrative Procedures Act ("APA").[64] In support of its position, the Providers note that, in *Allina Health Servs. v. Sebelius* ("*Allina*"), the D.C. Circuit recently invalidated a different regulatory revision made in the same rulemaking.[65] In *Allina*, the D.C. Circuit vacated the Secretary's regulation requiring Part C days be included in the Medicare fraction where the Secretary's policy prior to October 1, 2004 was to exclude Part C days from the Medicare fraction. The D.C. Circuit concluded that the Part C days regulation was not a logical outgrowth of the proposed regulation and that the proposed rule was merely an indication that the Secretary was considering a clarification of existing policy rather a reversal of the existing policy.

The Providers put forward another challenge to the procedural validity of the revision to § 412.106(b)(2)(i) by arguing that the Secretary's FY 2005 regulations requiring inclusion of the non-covered days in the Medicare fraction were not the product of reasoned decision-making.[66] The Providers argue that the dual eligible days proposed rule as published in the FY 2004 IPPS proposed rule was equally misleading with respect to the Secretary's policy. As with the Secretary's Part C days policy, the Secretary adopted a policy with regard to dual eligible days that was the reverse of the proposed regulation and erroneously described the policy with respected to dual eligible days in the FY 2004 IPPS proposed rule. The Provider's contend that the convoluted nature of this rulemaking in which the Secretary both got her facts mixed up while at the same time shifting positions could only create among the public the type of hopeless confusion which the D.C. Circuit found in *Allina.*[67]

Accordingly, the Providers maintain that the Secretary denied the public a meaningful opportunity to comment on the proposed regulations. There was nothing in the proposed regulations that suggested the possibility of anything other than the inclusion of non-covered days in the Medicare fraction or inclusion of non-covered days in the Medicaid fraction. As a result, the Providers maintain, the public was deprived of a meaningful opportunity to comment.

Accordingly, the Providers asserted that the Secretary's regulations requiring inclusion of post-2004 non-covered days in the Medicare fraction must be vacated and, as a result, the pre-FY 2005 regulations would apply.[68] The Providers assert that "These pre-FY 2005 regulations

[64] *Id.* at Section I.B.4.
[65] 746 F. 3d 1102 (D.C. Cir. 2014)
[66] Provider's EJR Request at Section I.B.5.
[67] *Id.* at 1107.
[68] Providers' EJR Request at Section I.B.6.

command exclusion of all non-covered days from the *Medicare* fraction" and that "if those day must be excluded from the Medicare faction [*sic* fraction], then they must necessarily be included in the Medicaid fraction."

The EJR request also puts forward challenges to the substantive validity of the revision to § 412.106(b)(2)(i) in Sections I.B.7. Here, the Providers argue that "[t]he plain and unambiguous language of the Medicare Act mandates exclusion of non-covered days from the Medicare fraction, and inclusion of those days in the Medicaid fraction." The Providers contend that the statutory scheme establishes that Medicare secondary payor days and exhausted benefit days are not "entitled to benefits under Part A."[69]

Finally, the EJR request contends "[a]lternatively . . . that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to included [*sic* include] unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare fraction."[70] In making this "alternative" contention, the EJR request notes that "[t]his contention is a separate and independent basis for granting EJR in this case" and that "the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction."[71]

The Providers point out that there are no factual matters to be resolved with respect to the issue in these cases and the Board has jurisdiction over the appeals. The Providers maintain that EJR is appropriate since the Board is without the authority to grant the relief sought, namely a finding that, as a matter of law , 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid.

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) (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 2012.

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[69] *Id.* at 12 (citing to *Jewish Hosp. v. Secretary of Health & Human Servs.*, 19 F.3d 270 (6th Cir. 1994); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1264 (9th Cir. 1996).
[70] Providers' EJR request at 1.
[71] *Id.*

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*").[72] 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.[73]

On August 21, 2008, new regulations governing the Board were effective.[74] 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*").[75] 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.[76]

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

A. *Jurisdiction Limited to One Issue – the No-Pay Dual Eligible Days Issue*

The Board notes that, on first page of their EJR request, the Providers include another issue which states:

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[72] 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.).
[73] *Bethesda*, 108 S. Ct. at 1258-59.
[74] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[75] 201 F. Supp. 3d 131 (D.D.C. 2016).
[76] *Id.* at 142.

> ***Alternatively***, the provider contends [*sic* providers contend] that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to include unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare Fraction. *This contention is a separate* **and** *independent basis* for granting EJR in this case. As noted below, the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction.[77]

The Board observes that, pursuant to the regulation, 42 C.F.R. § 405.1837(a)(2), a provider has the right to a hearing as part of a group appeal for a cost reporting period, *only if* among other things, "[t]he matter at issue in the group appeal involves a *single* question of fact or interpretation of law, regulations or CMS Rulings with is common to each provider in the group."[78] To this end, 42 C.F.R. § 405.1837(f) provides "Limitations on group appeals" and specifies in Paragraph (1) that issues may not be added to any group appeals: "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may not add other questions of fact or law to the appeal*, regardless of whether the question is common to other members of the appeal . . . ."[79]

The Board finds that the statement above is a separate issue (as recognized by the Representative through the use of the words "separate and independent" contention) and that the statement above is a new issue that was ***improperly*** added to the appeal when the EJR request was filed. The group statement filed to establish this CIRP group clearly does not challenge how SSI entitlement is determined for purposes of the DSH adjustment calculation or contend that that "eligible but unpaid SSI days be included in the numerator of the Medicare Fraction." Rather, the group appeal challenges how *Medicare* entitlement is determined and asserts that unpaid dual eligible days should be excluded from the Medicare fraction. Since the SSI entitlement days issue is a new issue and was not part of the original group issue statement, the Board is required to dismiss the issue from the group appeal pursuant to 42 C.F.R. § 405.1837(f)(1).[80] Consequently, the Board hereby dismisses the issue from the appeal and denies the EJR request relative to improperly added SSI entitlement days issue.[81]

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[77] (Emphasis added.)
[78] (Emphasis added.)
[79] (Emphasis added.)
[80] Moreover, the Board notes that, even if there was not the prohibition against adding issues to group appeals, the addition of this issue could not be considered timely since: (1) the add issue regulation at 42 C.F.R. § 405.1835(e) only applies to adding issues to individual appeal requests; and (2) the SSI days issue was not added to the group within the 180-day time period, as required by 42 C.F.R. § 405.1837(a)(1) (which incorporates § 405.1835(a) or § 405.1835(c)) and, thus, would not be timely.
[81] The Board further notes that the Provider failed to brief this improperly added issue as part of its EJR request.

B. Scope of Eligible Days Issue Limited to Medicare Fraction

Similar to 42 C.F.R. § 405.1835(b), 42 C.F.R. § 405.1837(c) (2014) specifies that request for a group appeal contain the following:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) An explanation (for each specific item at issue; see §405.1835(a)(1)) of each provider's dissatisfaction with its contractor or Secretary determination under appeal, including an account of—
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item;
>
> (ii) **How and why the provider believes Medicare payment must be determined differently for each disputed item**; and
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement sought for each item.
>
> (3) A copy of each contractor or Secretary determination under appeal, and any other documentary evidence the providers consider necessary to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and **a precise description** of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matters at issue in the group appeal; and
>
> (4) A statement that—
>
> (i) The providers believe they have satisfied all of the requirements for a group appeal hearing request under paragraph (a) of this section and requesting the Board to proceed to make jurisdictional findings in accordance with § 405.1840; or
>
> (ii) The Board is requested to defer making jurisdictional findings until the providers request the findings in accordance with paragraph (e)(2) of this section.

The Providers' issue statement filed to establish this CIRP group only appealed the SSI fraction and does not dispute the Medicaid fraction.[82] As part of the group appeal request, 42 C.F.R. § 405.1837(c)(2) required the group appeal request to include a "precise description" of the one question of fact or law common to the group and to explain both "how and why" Medicare payment must be determined differently. In compliance with this regulation, the group issue statement only requested the relief that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula."

In this regard, the Providers EJR request tried to analogize to Part C days to support its position that, if the no-pay days are excluded from the Medicare fraction, they must automatically be counted in both the numerator and denominator of the Medicaid fraction. However, the Board notes that, contrary to the Providers assertion, no-pay dual eligible days differ from Medicare Part C days. The Medicare Part C days issue deals with the days associated with a *class of patients*. Either ***all*** of the days associated with Medicare Part C beneficiaries are "entitled" to Medicare Part A or not. If they are not so entitled, then they are included in the Medicaid fraction by the clear terms of the DSH statute as the D.C. Circuit explained in *Allina*.[83]

With regard to the dual eligible days issue, all Medicare beneficiaries have Medicare Part A, and as such, it is clear, as a *patient class*, days associated my not be included *in toto* from the Medicare fraction. Rather, the Providers are asserting that only in certain ***no-pay*** dual eligible situations (*e.g.*, exhausted benefits and MSP) must days associated with this class of patients be excluded from the SSI fraction. As a result, the Board disagrees with the Providers' assertion that exclusion of days associated with these no-pay dual eligible situations automatically means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*")[84] and CMS Ruling 1498-R2 wherein multiple possible treatments of no-pay dual eligible days are discussed. Indeed, the relief requested by the Providers appears to be consistent with the Administrator's 2000 decision in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[85]

Based on the above, the Board finds that the Providers' EJR request is limited to the relief requested in the group issue statement, namely that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula." As a result, the Board strikes those portions of the Representative's EJR request requesting the relief that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."

The Board notes that the relief being requested in the group issue statement for this CIRP group is not inconsistent with the Ninth Circuit's decision in *Empire* wherein it relied on the Ninth Circuit's earlier decision in *Legacy* to: (1) find that the FY 2005 IPPS Final Rule's revision to 42

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[82] The only references to the Medicaid fraction are statements of alleged facts and do not include any assertion that the Medicaid fraction was *incorrectly* calculated (much less express dissatisfaction with the Medicaid fraction).
[83] 746 F.3d at 1108.
[84] 718 F.3d 914 (D.C. Cir. 2013).
[85] *See* 718 F.3d at 918, 92122 (discussing the *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years ealier in *Edgewater*").

C.F.R. § 412.106(b)(2)(i) was *substantively* invalid and (2) reinstate the regulation or rule previously in effect. Rather, the relief requested is seeking to address what *Empire* does not address, namely the regulation or rule previously in effect.[86]

C. Jurisdiction and EJR for the Four Reinstated Providers

The Board has determined that #2 Providence Little Company of Mary-San Pedro (Prov. No. 05-0078, FYE 12/31/12), #3 Providence St. Joseph Medical Center (Prov. No. 05-0245, FYE 12/31/12), #4 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/12), and #5 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/12), as participants in Case No. 15-0929GC and involved with the instant EJR request are governed by CMS Ruling CMS-1727-R as the Providers are challenging the validity of a regulation as it relates to Dual Eligible Days. Finally, the appeals were timely filed and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[87] Based on the above, the Board finds that it has jurisdiction for the above-captioned Providers' appeals. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

The Board finds that it lacks the authority to grant the relief sought by the Providers, namely a finding that 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid. Consequently, the Board finds that EJR is appropriate.

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that #2 Providence Little Company of Mary-San Pedro (provider no. 05-0078, FYE 12/31/12), #3 Providence St. Joseph Medical Center (provider no. 05-0245, FYE 12/31/12), #4 Providence Holy Cross Medical Center (provider no. 05-0278, FYE 12/31/12), and #5 Providence Little Company of Mary-Torrance (provider no. 05-0353, FYE 12/31/12) as participants in case number 15-0929GC, are entitled to a hearing before the Board;

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

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

[86] The Board notes that, even though subsequent to the EJR request being filed the Ninth Circuit issued its decision in *Empire*, the Group Representative did not seek to supplement its EJR request (notwithstanding the fact that the Group Representative was the representative for that case when it was before the Board). Rather, the Group Representative filed a request on October 29. 2020 requesting that the Board issue a decision on its EJR request by November 30, 2020.
[87] *See* 42 C.F.R. § 405.1837.

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i) codifying the Medicare dual eligible days policy adopted in the FY 2005 IPPS final rule is valid and to provide the requested relief that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula."

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (2005) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants #2 Providence Little Company of Mary-San Pedro (Prov. No. 05-0078, FYE 12/31/12), #3 Providence St. Joseph Medical Center (Prov. No. 05-0245, FYE 12/31/12), #4 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/12), and #5 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/12), as participants in Case No. 15-0929GC, request for EJR for the issue and the subject year as noted above. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board once again closes the case.

Board Members Participating:

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

FOR THE BOARD:

3/24/2021

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdiction Decision in Whole***
Memorial Medical Center – Modesto (Prov. No. 05-0557)
FYE: 12/31/2005
PRRB Case: 17-0552

Dear Mr. Jaeger and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the Disproportionate Share Hospital ("DSH") SSI Ratio, Realignment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts

On June 6, 2016, the Provider was issued a revised Notice of Program Reimbursement ("RNPR") for fiscal year ending December 31, 2005. The RNPR was issued on June 6, 2016 and there is an adjustment to "adjust the SSI% pursuant to the remand related to PRRB Case No. 07-2441G[1]."

The Provider filed an individual appeal request with the Board on November 30, 2016. The Individual Appeal Request contained five (5) issues which all concerned components of the Medicare disproportionate share hospital percentage:

Issue 1: Medicare DSH – SSI Ratio, Realignment
Issue 2: Medicare DSH – SSI Ratio, Accurate Data – *Transferred to PRRB No. 19-0160GC*
Issue 3: Medicare DSH – Inclusion of Medicare Part C Managed Care Days in the SSI Ratio Issued March 2012 - *Transferred to PRRB No. 19-0158GC*
Issue 4: Medicare DSH – Inclusion of Medicare Dual Eligible Part A Days in the SSI Ratio Issued March 16, 2012 – *Transferred to PRRB No. 19-0148GC*

[1] This case number is a typo. It is an individual appeal for a different provider.

Issue 5: Medicare DSH – SSI MMA Section 951 Applicable to SSI Ratio Issued March 2012 – *Transferred to PRRB No. 19-0161GC*

As indicated above, the Provider has requested transfer of four of the five issues to group appeals, including Issue 2 (the SSI Ratio, Accurate Data issue) to the CIRP group under Case No. 19-0160GC, entitled "Sutter Health CY 2005 Medicare DSH Calculation - SSI Accurate Data CIRP Group."

As a result, the sole issue that remains pending in the subject case is Issue 1 (the Medicare DSH – SSI Ratio, Realignment). In appealing this issue, the Provider contends that the "SSI percentage as generated by the Social Security Administration (SSA) and put forth by CMS is understated." Further, as part of this issue, the Provider seeks to preserve its right to realign the SSI percentage from the federal fiscal year to using the Provider's fiscal period.[2]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2016), 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.

As explained below, the Board hereby dismisses Issue 1 – the Medicare DSH – SSI Ratio, Realignment issue – in its entirety. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider as Issue 1 has two components: (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 component 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 Issue 2 (the Medicare DSH – SSI Ratio, Accurate Data issue) that was transferred to the CIRP group under Case No. 19-0160GC.

For Issue 1 (The DSH – SSI Ratio, Realignment issue), the Provider contends that "the SSI percentage as generated by the Social Security Administration (SSA) and put forth by CMS is *understated*."[3] Since the Provider is required to use the SSI percentage assigned by CMS rather than using an internally generated SSI percentage, the Provider contends that it "validly self-disallowed such an internally generated percentage in favor of that promulgated by CMS."[4] Significantly, the Provider admits that Issue 1 "is common to other related parties and Sutter

[2] RNPR Statement of Appeal Issues at 2 (Nov. 29, 2016).
[3] (Emphasis added.)
[4] RNPR Statement of Appeal Issues at 2 (November 29, 2016).

Health will transfer this issue into its mandatory common issue related party (CIRP) group appeal subsequent to this individual request."

For Issue 2 (the Medicare DSH – SSI Ratio, Accurate Data issue), the Provider again contends that "the SSI percentage as generated by the Social Security Administration (SSA) and put forth by CMS is *understated*."[5] The Provider further contends that "CMS did not use the best data available at the time of settlement to calculate the SSI fraction because of various reasons including but not limited to, not using updated current data, using data that excluded inactive claims, retroactive claims and what is sometimes referred to as forced or manual pay claims." The CIRP group to which Issue 2 was transferred (i.e., group Case No. 19-0160GC) similarly alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage since they failed to use the best data available at the time. The Provider also contends that the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

Based on the above, the Board finds that "understated" component of Issue 1 (the Medicare DSH – SSI Ratio, Realignment issue) in this appeal is duplicative of Issue 2 that was transferred to the CIRP group under Case No. 19-0160GC (the Medicare DSH – SSI Ratio, Accurate Data issue).[6] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of Issue 1 (the DSH/SSI Ratio, Realignment issue).

The second component of this issue is the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. The Provider preserving its right to request realignment of the SSI is dismissed by the Board due to 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 appeal. Without a final determination, the dissatisfaction requirement cannot be met for the Board to have jurisdiction. Therefore, the dissatisfaction requirement is not met and the Board does not jurisdiction over this issue.

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[5] (Emphasis added.)

[6] Moreover, the Board notes that there are alternative bases for dismissal. First, the Provider's appeal request did not properly lay out the "understated" component of Issue 1 with sufficient specificity; merely asserting that the SSI percentage is "understated" without further explanation or description does not comply with 42 C.F.R. § 405.1835(b) and Board Rule 8 (2015). In this regard, the Board notes that the SSI percentage has historically had many different components or aspects disputed by the provider community and that Board Rule 8.1 states: "Some issues may have multiple components. To comply with the regulatory requirement to *specifically identify the items in dispute*, each contested component must be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7." Second, the Provider admits Issue 1 is an issue common to Sutter Health and was required to be transferred to a CIRP but failed to do so.

Conclusion

The Board dismisses Issue 1 (the SSI Ratio, Realignment issue) in its entirety from this appeal. As no issues remain pending in the appeal, the Board hereby close Case No. 17-0552 and removed it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

3/25/2021

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services
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RE: ***Reinstatement and EJR Determination***
\# 3 Providence Holy Cross Medical Center (provider no. 05-0278, FYE 12/31/2014)
\# 4 Providence Little Company of Mary-Torrance (provider no. 05-0353, FYE 12/31/2014)
\# 5 Providence Tarzana Medical Center (provider no. 05-0761, FYE 12/31/2014)
as participants in:
17-0950GC QRS Providence 2014 SSI-Dual Eligible Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Group Representative's January 7, 2021 request to reinstate the three providers referenced above into case number 17-0950GC. In addition, the Providers in this group appeal had filed a request for expedited judicial review ("EJR") for the above-referenced common issue related party ("CIRP") group appeal on March 13, 2020, and the Board issued a decision with respect to the remaining Providers in case number 17-0905GC on November 30, 2020.[1] *The Board hereby supplements its November 30, 2020 determination*, and set forth below is the Board's determination regarding the request for reinstatement and EJR for # 3 Providence Holy Cross Medical Center, #4 Providence Little Company of Mary-Torrance and #5 Providence Tarzana Medical Center.

Effect of COVID -19 on Board Operations and Staying of the 30-day Period to Respond to EJR Requests:

By letter dated April 4, 2020, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services ("CMS") required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On April 9, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the

[1] The EJR also included a number of other case numbers. The Board has responded to the original request for EJR in those cases under separate cover.

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

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on March 3, 2020, the Board did not receive the EJR request for the above-referenced appeal in its office until March 13, 2020, after the Board and its staff had begun to telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers submitted March 3, 2020. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

Reinstatement Request

In the case of # 3 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/2014), # 4 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/2014), and # 5 Providence Tarzana Medical Center (Prov. No. 05-0761, FYE 12/31/2014), the Providers failed to include proof of delivery of their respective hearing requests in the jurisdictional documents accompanying the Schedule of Providers as required by Board Rule 21.3.2.[2] Instead, the Providers each included a notice that appeared to be the document produced when a shipping label is generated for a shipment using the shipper's website and did not demonstrate when the package was received by the addressee or sent by the shipper. Rule 21.3.2 requires that when a Schedule of Providers is filed with the Board each Provider must include:

> A copy of the relevant pages from the initial appeal request (Model Form A or E) and the request to add an issue, if applicable (Model Form C), including the issue statement, or other written requests filed prior to the use of such Model Forms in which this issue was appealed for the first time. In addition, if the appeal was filed after August 21, 2008, include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue.[3]

Consequently, the Board dismissed the Providers as part of the jurisdictional determination made in conjunction with the EJR decision in Case No. 17-0950GC issued on November 30, 2020.[4]

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[2] The Board's Rules are found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.
[3] The Board notes that this rule is consistent with 42 C.F.R. § 405.1837(a)(1) and (c) that require each provider demonstrate it satisfies individually the requirement for a Board hearing which includes the requirement that an appeal be timely filed with the Board.
[4] Jurisdiction over participants in a group appeal is a perquisite to granting a request for EJR. *See* 42 C.F.R.

On January 7, 2021, the Group Representative asked that the appeals for # 3 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/2014), # 4 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/2014), and # 5 Providence Tarzana Medical Center (Prov. No. 05-0761, FYE 12/31/2014) be reinstated. In conjunction with this request, the Group Representative submitted copies of the FedEx proof of delivery for the hearing requests for all three Providers. Since the Group Representative has submitted the required proof of timely filing, the Board hereby reopens Case No. 17-0950GC and reinstates # 3 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/2014), # 4 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/2014), and # 5 Providence Tarzana Medical Center (Prov. No. 05-0761, FYE 12/31/2014). The Board decision with respect to the Providers' EJR request is set forth below.

EJR Decision

Issue in Dispute:

The group issue statement filed to establish this CIRP group is entitled "Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)" and it contains the following description of the issue:

> Whether patient days associated with Medicare Part A and Title XIX patients should be *excluded* from the SSI or ***Medicare*** fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have excluded from the SSI or ***Medicare*** fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.[5]

The group issue statement then provides the following "Statement of the Legal Basis":

> The Provider contends that the MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.

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§ 405.1842(a).

[5] (Emphasis added.)

> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. *The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment*.
>
> *It is the Provider's contention that these days must be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula*.[6]

The EJR request characterizes the group issue in this CIRP appeal as:

> Whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "*dual eligible*"), and for whom Medicare has not made payment for that inpatient stay (hereinafter referred to as *"noncovered days")* should be included in the Medicare fraction of the *Medicare* Disproportionate Share (DSH) adjustment, as alleged by the MAC [Medicare Administrative Contractor], or should be excluded *Medicare* fraction of the DSH adjustment, and instead included in the *Medicaid* fraction . . . .[7]

The EJR request specifies that the relief being requested is that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."[8]

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[6] (Italics emphasis added and bold and underline emphasis in original.)
[7] Providers' EJR request at 2-3 (emphasis in original).
[8] *Id.* at 1.

Statutory and Regulatory Background: Medicare DSH Payment

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[9] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[10]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[11] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[12]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[13] 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.[14] The DPP is defined as the sum of two fractions expressed as percentages.[15] 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 . . . .[16]

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.[17]

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[9] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[10] *Id.*
[11] *See* 42 U.S.C. § 1395ww(d)(5).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[13] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[14] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[15] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[16] (Emphasis added.)
[17] 42 C.F.R. § 412.106(b)(2)-(3).

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[18]

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.[19]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[20] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[21]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[22] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[23] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[24]

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if

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[18] (Emphasis added.)
[19] 42 C.F.R. § 412.106(b)(4).
[20] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.* at 27207-27208.

the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[25] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[26] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[27]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[28] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[29] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [30] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[31]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[32] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[33]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[34]

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[25] *Id.* at 27207-08.
[26] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[27] 68 Fed. Reg. at 27208.
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[33] *Id.*
[34] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only <u>***covered***</u> patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[35]
>
> ****
>
> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation.*[36]

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[37] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[38] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—

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[35] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[36] *Id.* at 49099 (emphasis added).
[37] *Id.*
[38] *See id.* at 49099, 49246.

> (i) *Determines the number of **covered** patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[39]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[40]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[41]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[42] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[43] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[44] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[45] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C.

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[39] (Emphasis added.)
[40] (Emphasis added.)
[41] *Id.*
[42] 317 F. Supp. 3d 168 (D.D.C. 2018).
[43] *Id.* at 172.
[44] *Id.* at 190.
[45] *Id.* at 194.

Circuit"); however, the D.C. Circuit later dismissed it.[46] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[47] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[48] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[49]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[50] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[51] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[52] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate contest in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[53] and that the regulation is procedurally invalid.[54]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[55] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[56] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[57] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in

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[46] *See* 2019 WL 668282.
[47] 718 F.3d 914 (2013).
[48] 657 F.3d 1 (D.C. Cir. 2011).
[49] 718 F.3d at 920.
[50] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[51] *Id.* at 1141.
[52] *Id.*
[53] *Id. at 1162.*
[54] *Id. at 1163*
[55] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir., Oct. 20, 2020). It is unclear if the Secretary will petition the U.S. Supreme Court to review the Ninth Circuit's *Empire* decision.
[56] *Id.* at 884.
[57] *Id.* at 884.

Legacy Emanuel Hospital and Health Center v. Shalala ("*Legacy Emanuel*")[58] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[59] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[60] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[61] Accordingly, the Ninth Circuit to the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force).

As of the date of this decision, the Secretary's position with respect to the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

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

The Providers contend that the non-covered patient, *i.e.*, days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make payment for their hospital stays because the patient's Medicare patient days were exhausted or because a third party made payment, should be excluded from the Medicare fraction of the DSH fraction. The Providers maintain *in their EJR request* that these non-covered patient days should be treated consistently: (1) they should be included in both the numerator and denominator of the SSI fraction; or (2) excluded from the numerator and denominator of the SSI fraction and then be recognized in the numerator of the Medicaid fraction.[62]

The Providers explain that the applicable regulations require that non-covered patient days be included in the Medicare fraction due to the change made to the regulations effective October 1, 2004. This was accomplished by the deletion of the word "covered" where it had previously appeared in the definition of the Medicare fraction in 42 C.F.R. § 412.106(b)(2)(i). As a result of this change, the regulation now requires the inclusion in the Medicare fraction of both exhausted

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[58] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[59] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[60] *Id.* at 886.
[61] *Id.*
[62] Providers' EJR Request at 2.

benefit and Medicare secondary payment days associated with patient discharges occurring on or after October 1, 2004.

The Providers assert that the Secretary improperly promulgated the revision to § 412.106(b)(2)(i) as part of the FY 2005 IPPS Final Rule and that this revision should be vacated due to *procedural* violations of the Administrative Procedures Act ("APA").[63] In support of its position, the Providers note that, in *Allina Health Servs. v. Sebelius* ("*Allina*"), the D.C. Circuit recently invalidated a different regulatory revision made in the same rulemaking.[64] In *Allina*, the D.C. Circuit vacated the Secretary's regulation requiring Part C days be included in the Medicare fraction where the Secretary's policy prior to October 1, 2004 was to exclude Part C days from the Medicare fraction. The D.C. Circuit concluded that the Part C days regulation was not a logical outgrowth of the proposed regulation and that the proposed rule was merely an indication that the Secretary was considering a clarification of existing policy rather a reversal of the existing policy.

The Providers put forward another challenge to the procedural validity of the revision to § 412.106(b)(2)(i) by arguing that the Secretary's FY 2005 regulations requiring inclusion of the non-covered days in the Medicare fraction were not the product of reasoned decision-making.[65] The Providers argue that the dual eligible days proposed rule as published in the FY 2004 IPPS proposed rule was equally misleading with respect to the Secretary's policy. As with the Secretary's Part C days policy, the Secretary adopted a policy with regard to dual eligible days that was the reverse of the proposed regulation and erroneously described the policy with respected to dual eligible days in the FY 2004 IPPS proposed rule. The Provider's contend that the convoluted nature of this rulemaking in which the Secretary both got her facts mixed up while at the same time shifting positions could only create among the public the type of hopeless confusion which the D.C. Circuit found in *Allina.*[66]

Accordingly, the Providers maintain that the Secretary denied the public a meaningful opportunity to comment on the proposed regulations. There was nothing in the proposed regulations that suggested the possibility of anything other than the inclusion of non-covered days in the Medicare fraction or inclusion of non-covered days in the Medicaid fraction. As a result, the Providers maintain, the public was deprived of a meaningful opportunity to comment.

Accordingly, the Providers asserted that the Secretary's regulations requiring inclusion of post-2004 non-covered days in the Medicare fraction must be vacated and, as a result, the pre-FY 2005 regulations would apply.[67] The Providers assert that "These pre-FY 2005 regulations command exclusion of all non-covered days from the *Medicare* fraction" and that "if those day must be excluded from the Medicare faction [*sic* fraction], then they must necessarily be included in the Medicaid fraction."

[63] *Id.* at Section I.B.4.
[64] 746 F. 3d 1102 (D.C. Cir. 2014)
[65] Provider's EJR Request at Section I.B.5.
[66] *Id.* at 1107.
[67] Providers' EJR Request at Section I.B.6.

The EJR request also puts forward challenges to the substantive validity of the revision to § 412.106(b)(2)(i) in Sections I.B.7. Here, the Providers argue that "[t]he plain and unambiguous language of the Medicare Act mandates exclusion of non-covered days from the Medicare fraction, and inclusion of those days in the Medicaid fraction." The Providers contend that the statutory scheme establishes that Medicare secondary payor days and exhausted benefit days are not "entitled to benefits under Part A."[68]

Finally, the EJR request contends "[a]lternatively . . . that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to included [*sic* include] unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare fraction."[69] In making this "alternative" contention, the EJR request notes that "[t]his contention is a separate and independent basis for granting EJR in this case" and that "the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction."[70]

The Providers point out that there are no factual matters to be resolved with respect to the issue in these cases and the Board has jurisdiction over the appeals. The Providers maintain that EJR is appropriate since the Board is without the authority to grant the relief sought, namely a finding that, as a matter of law , 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid.

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) (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 2014.

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

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[68] *Id.* at 12 (citing to *Jewish Hosp. v. Secretary of Health & Human Servs.*, 19 F.3d 270 (6th Cir. 1994); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1264 (9th Cir. 1996).
[69] Providers' EJR request at 1.
[70] *Id.*

Bowen ("*Bethesda*").[71] 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.[72]

On August 21, 2008, new regulations governing the Board were effective.[73] 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*").[74] 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.[75]

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

A. *Jurisdiction Limited to One Issue – the No-Pay Dual Eligible Days Issue*

The Board notes that, on first page of their EJR request, the Providers include another issue which states:

> ***Alternatively***, the provider contends [*sic* providers contend] that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to include unpaid (i.e., non-covered days that are not paid by Medicare) in the

[71] 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.).
[72] *Bethesda*, 108 S. Ct. at 1258-59.
[73] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[74] 201 F. Supp. 3d 131 (D.D.C. 2016).
[75] *Id.* at 142.

> denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare Fraction. *This contention is a separate **and** independent basis* for granting EJR in this case. As noted below, the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction.[76]

The Board observes that, pursuant to the regulation, 42 C.F.R. § 405.1837(a)(2), a provider has the right to a hearing as part of a group appeal for a cost reporting period, *only if* among other things, "[t]he matter at issue in the group appeal involves a *single* question of fact or interpretation of law, regulations or CMS Rulings with is common to each provider in the group."[77] To this end, 42 C.F.R. § 405.1837(f) provides "Limitations on group appeals" and specifies in Paragraph (1) that issues may not be added to any group appeals: "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may not add other questions of fact or law to the appeal*, regardless of whether the question is common to other members of the appeal . . . ."[78]

The Board finds that the statement above is a separate issue (as recognized by the Representative through the use of the words "separate and independent" contention) and that the statement above is a new issue that was ***improperly*** added to the appeal when the EJR request was filed. The group statement filed to establish this CIRP group clearly does not challenge how SSI entitlement is determined for purposes of the DSH adjustment calculation or contend that that "eligible but unpaid SSI days be included in the numerator of the Medicare Fraction." Rather, the group appeal challenges how *Medicare* entitlement is determined and asserts that unpaid dual eligible days should be excluded from the Medicare fraction. Since the SSI entitlement days issue is a new issue and was not part of the original group issue statement, the Board is required to dismiss the issue from the group appeal pursuant to 42 C.F.R. § 405.1837(f)(1).[79] Consequently, the Board hereby dismisses the issue from the appeal and denies the EJR request relative to improperly added SSI entitlement days issue.[80]

B. Scope of Eligible Days Issue Limited to Medicare Fraction

Similar to 42 C.F.R. § 405.1835(b), 42 C.F.R. § 405.1837(c) (2014) specifies that request for a group appeal contain the following:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:

[76] (Emphasis added.)
[77] (Emphasis added.)
[78] (Emphasis added.)
[79] Moreover, the Board notes that, even if there was not the prohibition against adding issues to group appeals, the addition of this issue could not be considered timely since: (1) the add issue regulation at 42 C.F.R. § 405.1835(e) only applies to adding issues to individual appeal requests; and (2) the SSI days issue was not added to the group within the 180-day time period, as required by 42 C.F.R. § 405.1837(a)(1) (which incorporates § 405.1835(a) or § 405.1835(c)) and, thus, would not be timely.
[80] The Board further notes that the Provider failed to brief this improperly added issue as part of its EJR request.

> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) An explanation (for each specific item at issue; see §405.1835(a)(1)) of each provider's dissatisfaction with its contractor or Secretary determination under appeal, including an account of—
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item;
>
> (ii) **How and why the provider believes Medicare payment must be determined differently for each disputed item**; and
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement sought for each item.
>
> (3) A copy of each contractor or Secretary determination under appeal, and any other documentary evidence the providers consider necessary to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and **a precise description** of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matters at issue in the group appeal; and
>
> (4) A statement that—
>
> (i) The providers believe they have satisfied all of the requirements for a group appeal hearing request under paragraph (a) of this section and requesting the Board to proceed to make jurisdictional findings in accordance with § 405.1840; or
>
> (ii) The Board is requested to defer making jurisdictional findings until the providers request the findings in accordance with paragraph (e)(2) of this section.

The Providers' issue statement filed to establish this CIRP group only appealed the SSI fraction and does not dispute the Medicaid fraction.[81] As part of the group appeal request, 42 C.F.R. § 405.1837(c)(2) required the group appeal request to include a "precise description" of the one question of fact or law common to the group and to explain both "how and why" Medicare payment must be determined differently. In compliance with this regulation, the group issue

[81] The only references to the Medicaid fraction are statements of alleged facts and do not include any assertion that the Medicaid fraction was *incorrectly* calculated (much less express dissatisfaction with the Medicaid fraction).

statement only requested the relief that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula."

In this regard, the Providers' EJR request tried to analogize to Part C days to support its position that, if the no-pay days are excluded from the Medicare fraction, they must automatically be counted in both the numerator and denominator of the Medicaid fraction. However, the Board notes that, contrary to the Providers assertion, no-pay dual eligible days differ from Medicare Part C days. The Medicare Part C days issue deals with the days associated with a *class of patients*. Either ***all*** of the days associated with Medicare Part C beneficiaries are "entitled" to Medicare Part A or not. If they are not so entitled, then they are included in the Medicaid fraction by the clear terms of the DSH statute as the D.C. Circuit explained in *Allina*.[82]

With regard to the dual eligible days issue, all Medicare beneficiaries have Medicare Part A, and as such, it is clear, as a *patient class*, days associated my not be included *in toto* from the Medicare fraction. Rather, the Providers are asserting that only in certain ***no-pay*** dual eligible situations (*e.g.*, exhausted benefits and MSP) must days associated with this class of patients be excluded from the SSI fraction. As a result, the Board disagrees with the Providers' assertion that exclusion of days associated with these no-pay dual eligible situations automatically means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*")[83] and CMS Ruling 1498-R2 wherein multiple possible treatments of no-pay dual eligible days are discussed. Indeed, the relief requested by the Providers appears to be consistent with the Administrator's 2000 decision in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[84]

Based on the above, the Board finds that the Providers' EJR request is limited to the relief requested in the group issue statement, namely that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula." As a result, the Board strikes those portions of the Representative's EJR request requesting the relief that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."

The Board notes that the relief being requested in the group issue statement for this CIRP group is not inconsistent with the Ninth Circuit's decision in *Empire* wherein it relied on the Ninth Circuit's earlier decision in *Legacy* to: (1) find that the FY 2005 IPPS Final Rule's revision to 42 C.F.R. § 412.106(b)(2)(i) was *substantively* invalid and (2) reinstate the regulation or rule previously in effect. Rather, the relief requested is seeking to address what *Empire* does not address, namely the regulation or rule previously in effect.[85]

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[82] 746 F.3d at 1108.
[83] 718 F.3d 914 (D.C. Cir. 2013).
[84] *See* 718 F.3d at 918, 92122 (discussing the *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years ealier in *Edgewater*").
[85] The Board notes that, even though subsequent to the EJR request being filed the Ninth Circuit issued its decision in *Empire*, the Group Representative did not seek to supplement its EJR request (notwithstanding the fact that the Group Representative was the representative for that case when it was before the Board). Rather, the Group

C. Jurisdiction and EJR for the Three Reinstated Providers

The Board has determined that # 3 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/2014), # 4 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/2014), and # 5 Providence Tarzana Medical Center (Prov. No. 05-0761, FYE 12/31/2014) as participants in Case No. 17-0950GC and involved with the instant EJR request are governed by CMS Ruling CMS-1727-R as the Providers are challenging the validity of a regulation as it relates to Dual Eligible Days. Finally, the appeals were timely filed and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[86] Based on the above, the Board finds that it has jurisdiction for the above-captioned Providers' appeals. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

The Board finds that it lacks the authority to grant the relief sought by the Providers, namely a finding that 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid. Consequently, the Board finds that EJR is appropriate.

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 # 3 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/2014), # 4 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/2014), and # 5 Providence Tarzana Medical Center (Prov. No. 05-0761, FYE 12/31/2014) in Case No. 17-0950GC, are entitled to a hearing before the Board;

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

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) codifying the Medicare dual eligible days policy adopted in the FY 2005 IPPS final rule is valid and to provide the requested relief that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula."

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (2005) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants # 3

Representative filed a request on October 29. 2020 requesting that the Board issue a decision on its EJR request by November 30, 2020.

[86] *See* 42 C.F.R. § 405.1837.

Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/2014), # 4 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/2014), and # 5 Providence Tarzana Medical Center (Prov. No. 05-0761, FYE 12/31/2014), as participants in Case No. 17-0950GC, request for EJR for the issue and the subject year as noted above. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

3/25/2021

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Mail Stop: N2-19-25
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Via Electronic Delivery

Dylan Chinea
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

Lorraine Frewert, Appeals Coordinator
Noridian Healthcare Solutions (J-E)
P.O. Box 6782
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RE: ***Jurisdictional Determination of Groups filed from SSI Realignment Determinations***
Toyon Associates CY 2014 Inclusion of Medicare Part C Days in the SSI Ratio #3 Group
Case No. **21-0342G**

Toyon Associates CY 2014 Accuracy of CMS Developed SSI Ratio #3 Group
Case No. **21-0343G**

Dear Mr. Chinea and Ms. Frewert:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced *optional* group appeals which each have only a single participant. The background of both groups, the pertinent facts related to the remaining participant in both groups and the jurisdictional decision of the Board, are set forth below.

Background of Groups:

Both optional group appeals were filed by Toyon Associates, Inc. ("Toyon"/"Representative") on December 9, 2020. The groups were formed in the Office of Hearings Case & Document Management System ("OH CDMS") without any participants.

A. Medicare Part C Days in the SSI Ratio (Case No. 21-0342G)

The group issue statement indicates the group is appealing "Whether CMS' inclusion of Medicare Part C Days in the SSI Ratio was proper?"

Specifically, the providers contend that:

> CMS' new interpretation of including Medicare MA or Part C Days in the SSI ratio is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the Northeast Hospital decision. . . . The group maintains the position that all Medicare MA or Part C Days should be excluded from the SSI Ratio.

B. Accuracy of CMS Developed SSI Ratio (Case No. 21-0343G)

The group issue statement indicates the group is appealing "Whether the SSI Ratio developed by CMS is calculated accurately?"

Specifically, the providers contend that:

> CMS failed to disclose the underlying patient data of their calculation proving the SSI ratio is calculated in the manner prescribed by CMS Ruling 1498-R."

C. Providers Participating in Case Nos. 21-0342G and 21-0343G

On the same date that both groups were formed, Toyon submitted transfer requests for the following two Providers for the SSI Ratio Accuracy issue and Part C Days SSI Ratio issue to both groups:[1]

- Community Hospital of the Monterey Peninsula (Prov. No. 05-0145) was transferred from Case No. 20-1636; and
- Hollywood Presbyterian Medical Center (Prov. No. 05-0063) was transferred from Case No. 21-0233.[2]

Both Providers' individual appeals were filed from Revised Notices of Program Reimbursement ("NPR") that were issued as a result of Realignment Requests.

On March 2, 2021, the Board denied jurisdiction over the Part C Days SSIA Ratio issue and the SSI Ratio Accuracy issue for Hollywood Presbyterian Medical Center ("Hollywood") and, as a result, dismissed those issues from Case No. 21-0233 and denied Hollywood's transfers of those issues to the subject optional groups.

Accordingly, Community Hospital of the Monterey Peninsula is the sole remaining participant in the subject optional groups.

<u>Pertinent Facts for Remaining Provider in Case Nos. 21-0342G and 21-0343G</u>:

As noted above, Community Hospital of the Monterey Peninsula (Prov. No. 05-0145) for FYE 12/31/2014 is the sole participant remaining in Case Nos. 21-0342G and 21-0343G. The Provider's Cost Reporting Reopening and SSI Ratio Realignment Requests is dated March 12, 2019 and states: "[The Provider]. . . requests a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year. The Provider's cost reporting period is January 1, 2014 to December 31, 2014." On May 10, 2019, the Medicare Contractor issued a Notice of Reopening of Cost report on May 10, 2019, which was issued:

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[1] Both optional groups are not due to be complete (fully formed) until December 9, 2021.

[2] Hollywood Presbyterian Medical Center's individual appeal, Case No. 21-0233 was dismissed by the Board in a letter dated March 2, 2021. Consequently, the Board also denied the Provider's two transfer requests to Case Nos. 21-0342G and 21-0343G.

> To adjust the SSI ratio used to calculate the providers disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year end and to amend the disproportionate share adjustment to account for the change is SSI ratio.

The Provider was issued Revised NPR on November 26, 2019, from which it filed its individual appeal with two issues. The issues under appeal both reference Audit Adjustment #4 which was made "[t]o adjust SSI Percentage and Disproportionate Share Amount based on the latest CMS Letter of SSI Percentage Realignment."

Board Determination

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

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

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

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

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

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination.* A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if –
>
> (1) The Provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception:** If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contract's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[3]

The Board finds that it does not have jurisdiction over both the SSI Accuracy and SSI Ratio Part C Days issues for **Community Hospital of the Monterey Peninsula,** *as a participant in these optional groups*, which it appealed from a revised NPR, because the revised NPR was issued as a result of the Provider's SSI realignment request, and did not specifically adjust these issues. As a result, the provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The reopening for this group participant was issued as a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to the individual cost reporting fiscal year end. The audit adjustment associated with the revised NPR under appeal for both issues (#4) clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[5] In other words, the determination was only being reopened to include

[3] Emphasis added.
[4] 42 C.F.R. § 405.1889(b)(1).
[5] 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). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See*

the realigned SSI percentage and CMS' realignment process (as described in the Federal Register) does *not* entail re-running of the data matching process that the Provider is trying to appeal (mush less revise any of the Part C days included in the underlying month-by-month data).[6] Indeed, CMS' policy states that the Provider must accept the realigned SSI ratio.[7] Since the only matter specifically revised in the revised NPR was an adjustment related to realigning the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over Community Hospital of the Monterey Peninsula for either the SSI Ratio Accuracy issue or the SSI Ratio Part C Days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[8]

Finally, as there are no remaining participants in the groups, Case Nos. 21-0342G and 21-0343G are hereby closed. 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:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

3/29/2021

X Clayton J. Nix

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

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

---

42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] *See supra* note 5.

[7] *See supra* note 5 (quoting 70 Fed. Reg. at 47439).

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Determination***
San Francisco General Hospital, (Prov. No. 05-0228) FYE 06/30/2010
Case No. 20-2019

Dear Ms. Ellis and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

The Provider filed a Reopening Request on August 28, 2019. In its request, the Provider requests ". . . a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year."

The Medicare Contractor ("MAC") issued a Notice of Reopening on September 25, 2019, in which it advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on data from the hospital's actual cost reporting period rather than the fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio." On March 16, 2020, the MAC issued the revised determination as a Notice of Amount of Corrected Program Reimbursement ("RNPR") on March 16, 2020.

On August 28, 2020, Toyon Associates, Inc. ("Toyon") filed an individual appeal of the RNPR with the Board and the Board assigned it to Case No. 20-2019.[1] The appeal only included the following two issues:

[1] *In violation of Board Rule 6.3*, Toyon filed a separate appeal for the RNPR rather than using the "Add Determination" case action to add it to the pending appeal for the Provider's FYE 06/30/2010 pending appeal (Case No. 19-0684) based on the original NPR. Board Rule 6.3 instructs providers to add the subsequent determination to the pending appeal covering the same fiscal year.

1. DSH Accuracy of CMS Developed SSI Ratio ("SSI Accuracy")
2. DSH Inclusion of Medicare Part C Days in the SSI Ratio ("SSI Fr. Part C Days")

For both issues, the Provider referenced Audit Adjustment #4 and #6. Both of these adjustments state that they were made: "To adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment."

Board Determination

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

Relevant Regulations – RNPRs

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

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

The Board finds that it does not have jurisdiction over the two issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider's SSI Realignment request, and did not specifically adjust these issues. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[2] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Provider's Request for Reopening, the MAC's Notice of Reopening, and the referenced audit adjustments, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[3] The realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis (*e.g.*, does not change data on Part C days) since CMS does not rerun the data matching process in order to effectuate a realignment. Indeed, to this end, CMS' realignment policy is that the provider must accept the realigned SSI percentage.[4] Since the only matter specifically revised in the RNPR was an adjustment to realign SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the SSI Accuracy or the SSI Fr. Part C days issues in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[5]

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[2] 42 C.F.R. § 405.1889(b)(1).

[3] CMS does not re-run the data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[4] *See supra* note 3 (quoting CMS realignment policy at 70 Fed. Reg. at 47439).

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

In addition, the Board directs the Representative's attention to Board Rule 6.3, which gives guidance on multiple determinations appealed by a Provider for the same fiscal year end. The Rule states:

> **6.3 Adding a New Determination to an Individual Case**
>
> **6.3.1 Request and Supporting Documentation**
>
> For individual appeals, an appeal may be for only one cost reporting period. *If multiple final determinations were issued* ***on different dates*** *for the cost reporting period being appealed (e.g., NPR, revised NPRs, exception request denials, etc.), providers* ***<u>must</u>*** *timely* ***request to add*** *the subsequent determination to its pending appeal for that cost reporting period.*" Reference Model Form A – Individual Appeal Request (Appendix A) for all required data fields and supporting documentation.[6]

Similarly, Board Rule 4.6 prohibits "Duplicate Filings":

> **4.6 No Duplicate Filings**
>
> **4.6.1 No Duplicate Filings Same Issue from One Determination**
> A provider may not appeal an issue from a single final determination in more than one appeal.
>
> **4.6.2 Same Issue from Multiple Determinations**
> Appeals of the same issue from distinct determinations must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals.
>
> **4.6.3 Issue Previously Dismissed or Withdrawn**
> Once an issue is dismissed or withdrawn, the issue may not be appealed in any other case.

Accordingly, in this instance, the appeal of the RNPR should have been added to the Provider's pending individual appeal under Case No. 19-0684 which, in addition to others, contained the **<u>same</u>** SSI Accuracy and Part C days issues addressed herein.[7] ***The Board directs the Representative to review Board Rules 4.6 and 6.3 for compliance to ensure duplicate individual appeals are not filed.*** *The Board also notes that the OH CDMS PRRB Module*

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[6] Board Rules (Aug. 29, 2018).

[7] The Board notes that the both the SSI Accuracy issue and the Part C Days issues were previously transferred from the original NPR appeal (Case No. 19-0684) to optional groups (Case No. 19-1685G and Case No. 19-1684G, respectively) on April 12, 2019.

External User Manual at §§ 3.3.4.3 and 3.3.4.3.1 describes how a determination may be added to an existing individual appeal in OH CDMS using the Case Correspondence Drop-Down Menu.[8]

In conclusion, the Board ***dismisses*** the two issues appealed from the RNPR in Case No. 20-2019 as the Provider does not have the right to appeal from the RNPR at issue for these issues. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 20-2019 and removes it from the Board's docket.

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

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

FOR THE BOARD:

3/30/2021

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

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

[8] OH CDMS PRRB Module External User Manual, Version 1.0, at 64-65 (Aug. 22, 2018) (PDF copy available at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Determination***
San Francisco General Hospital, (Prov. No. 05-0228) FYE 06/30/2011
PRRB Case No. 20-2024

Dear Ms. Ellis and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On April 20, 2016, the Provider filed a Reopening Request. In its request, the Provider requests ". . . a recalculation of its Hospital SSI ratio for purposes of aligning it with the Hospital's fiscal year ended 6/30/2011."

On September 25, 2019, the Medicare Contractor ("MAC") issued a Notice of Reopening in which it advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on data from the hospital's actual cost reporting period rather than the fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio."

On March 16, 2020, the MAC issued the Notice of Amount of Corrected Program Reimbursement (Revised NPR ("RNPR")).

On August 31, 2020, Toyon Associates, Inc. ("Toyon") filed an individual appeal of the RNPR with the Board to which the Board assigned Case No. 20-2024.[1] The appeal included two issues:

DSH Accuracy of CMS Developed SSI Ratio ("SSI Accuracy")
DSH Inclusion of Medicare Part C Days in the SSI Ratio ("SSI Fr. Part C Days")

[1] As discussed *infra*, Toyon ***improperly*** filed a separate appeal for the RNPR rather than using the "Add Determination" case action to add it to the pending appeal for the Provider's FYE 06/30/2011 pending NPR based appeal (Case No. 19-0683).

For both issues, the Provider referenced Audit Adjustment #4. Audit Adjustment #4 was issued "[t]o adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment."

Board Determination

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

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

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

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

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

The Board finds that it does not have jurisdiction over the two issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment

request, and did not specifically adjust these issues. As a result, the provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[2] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Provider's Request for Reopening, the MAC's Notice of Reopening, and the referenced audit adjustment, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[3] The realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis (*e.g.*, does not change data on Part C days) since CMS does not rerun the data matching process in order to effectuate a realignment. Indeed, to this end, CMS' realignment policy is that the provider must accept the realigned SSI percentage.[4] Since the only matter specifically revised in the RNPR was an adjustment to realign SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the SSI Accuracy or the SSI Fr. Part C days issues in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[5]

In addition, the Board directs the Representative's attention to Board Rule 6.3, which gives guidance on multiple determinations appealed by a Provider for the same fiscal year end. The Rule states:

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[2] 42 C.F.R. § 405.1889(b)(1).

[3] CMS does not re-run the data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[4] *See supra* note 3 (quoting CMS realignment policy at 70 Fed. Reg. at 47439).

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

6.3 Adding a New Determination to an Individual Case

6.3.1 Request and Supporting Documentation

For individual appeals, an appeal may be for only one cost reporting period. *If multiple final determinations were issued* ***on different dates*** *for the cost reporting period being appealed(e.g., NPR, revised NPRs, exception request denials, etc.), providers* ***must*** *timely request to add the subsequent determination to its pending appeal for that cost reporting period.*" Reference Model Form A – Individual Appeal Request (Appendix A) for all required data fields and supporting documentation.[6]

Similarly, Board Rule 4.6 prohibits "Duplicate Filings":

4.6 No Duplicate Filings

4.6.1 No Duplicate Filings Same Issue from One Determination
A provider may not appeal an issue from a single final determination in more than one appeal.

4.6.2 Same Issue from Multiple Determinations
Appeals of the same issue from distinct determinations must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals.

4.6.3 Issue Previously Dismissed or Withdrawn
Once an issue is dismissed or withdrawn, the issue may not be appealed in any other case.

Accordingly, in this instance, the appeal of the RNPR should have been added to the Provider's pending individual appeal under Case No. 19-0683 which, in addition to others, contained the **same** SSI Accuracy issue addressed herein.[7] ***The Board directs the Representative to review Board Rules 4.6 and 6.3 and come into compliance with them to ensure duplicate individual appeals are not filed.*** *The Board also notes that the OH CDMS PRRB Module External User Manual at §§ 3.3.4.3 and 3.3.4.3.1 describes how a determination may be added to an existing individual appeal in OH CDMS using the Case Correspondence Drop-Down Menu.*[8]

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[6] Board Rules. (Aug. 29, 2018)
[7] The Board notes that the SSI Accuracy issue was previously transferred from the original NPR appeal (Case No. 19-0683) to an optional group (Case No. 19-1685G) on August 29, 2019.
[8] OH CDMS PRRB Module External User Manual, Version 1.0, at 64-65 (Aug. 22, 2018) (PDF copy available at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing).

* * * * *

In conclusion, the Board ***dismisses*** the two issues appealed from the RNPR in Case No. 20-2024 as the Provider does not have the right to appeal the RNPR at issue for these issues. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 20-2024 and removes it from the Board's docket.

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

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

FOR THE BOARD:

3/31/2021

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Wade H. Jaeger
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Lorraine Frewert
Noridian Healthcare Solutions c/o Cahaba
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RE: ***Jurisdictional Determination***
Alta Bates Summit Medical Center (Prov. No. 05-0043, FYE 12/31/2015)
Case No. 21-0408

Dear Mr. Sutter and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response the Representative's March 12, 2021 requests to transfer issues to common issue related party ("CIRP") groups. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On August 29, 2019, the Medicare Contractor issued the Notice of Reopening in which it advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio." On July 14, 2020, the Medicare Contractor issued the Notice of Amount of Corrected Reimbursement ("RNPR").[1]

On December 22, 2020, Sutter Health filed an individual appeal from the RNPR and the Board assigned it to Case No. 21-0408.[2] The RNPR appeal included six issues:

DSH SSI Ratio – Inaccurate Data (SSI Accuracy)
DSH SSI Ratio Part C Days (SSI Fr. Part C days)
DSH SSI Ratio Part A Days (SSI Fr. Part A days)
DSH SSI Ratio MMA Section 951 (SSI MMA Section 951)
DSH Medicaid Dual Eligible Part C Days (M'caid Fr. Part C days)

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[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").

[2] Sutter Health ***improperly*** filed a separate appeal for the RNPR rather than using the "Add Determination" case action to add it to the pending appeal for the Provider's FYE 12/31/2015 pending NPR based appeal (Case No. 19-2038). The Board further notes that Sutter Health ***improperly*** filed another ***duplicate*** appeal for the Provider's FYE 12/31/2015 under Case No. 20-1327.

DSH Medicaid Dual Eligible Part A Days (M'caid Fr. Part A days)

For all six issued, the Provider referenced Audit Adjustment # 5 in the RNPR. Audit Adjustment No. 5 is a generic adjustment issued "[t]o revise the SSI and DSH percentage." The cover page to the RNPR references back to the reopening by stating, in pertinent part: "This is an addendum to the prior settlement dated May 25, 2016 Reason for Reopening: . . . To adjust the SSI ratio used to calculate the providers [DSH] adjustment based on data from the hospital's actual cost reporting period rather than the federal fiscal year . . . ."

On March 12, 2021, Sutter Health requested the following transfers from Case No. 21-0408:

Issue	To Group
SSI Accuracy	19-2051GC
SSI Fr. Part C days	19-2048GC
SSI Fr. Part A days	19-2049GC
SSI MMA Sect. 951	19-2050GC
M'caid Fr. Part C days	19-2052GC
M'caid Fr. Part A days	19-2053GC

Board Determination

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

Relevant Regulations – RNPRs

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

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

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

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

The Board finds that it does not have jurisdiction over the six issues in this individual appeal filed from the revised NPR because the revised NPR was issued as a result of the Provider' SSI Realignment request, and did not specifically adjust these issues. As a result, the provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Notice of Reopening, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[4] The realignment process (as described in the

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[3] 42 C.F.R. § 405.1889(b)(1).

[4] CMS does not re-run the data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the

Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis (*e.g.*, does not change data on either Part A or Part C days) since CMS does not rerun the data matching process in order to effectuate a realignment. Indeed, to this end, CMS' stated realignment policy is that the provider must accept the realigned SSI percentage.[5] Since the only matter specifically revised in the RNPR was an adjustment to realign the SSI percentage from federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the the SSI Accuracy, SSI Fr. Part C days, SSI Fr. Part A days, SSI MMA Section 951, M'caid Fr. Part C days, or M'caid Fr. Part A days issues in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[6]

In addition, the Board directs the Representative's attention to Board Rule 6.3, which gives guidance on multiple determinations appealed by a Provider for the same fiscal year end. The Rule states:

> **6.3 Adding a New Determination to an Individual Case**
>
> **6.3.1 Request and Supporting Documentation**
>
> For individual appeals, an appeal may be for only one cost reporting period. *If multiple final determinations were issued* ***on different dates*** *for the cost reporting period being appealed (e.g., NPR, revised NPRs, exception request denials, etc.), providers* ***must*** *timely* ***request to add*** *the subsequent determination to its pending appeal for that cost reporting period.*" Reference Model Form A – Individual Appeal Request (Appendix A) for all required data fields and supporting documentation.[7]

Similarly, Board Rule 4.6 prohibits "Duplicate Filings":

> **4.6 No Duplicate Filings**
>
> **4.6.1 No Duplicate Filings Same Issue from One Determination**
> A provider may not appeal an issue from a single final determination in more than one appeal.
>
> **4.6.2 Same Issue from Multiple Determinations**

---

hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[5] *See supra* note 4 (quoting CMS realignment policy at 70 Fed. Reg. at 47439).

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

[7] Board Rules (Aug. 29, 2018).

> Appeals of the same issue from distinct determinations must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals.
>
> **4.6.3 Issue Previously Dismissed or Withdrawn**
> Once an issue is dismissed or withdrawn, the issue may not be appealed in any other case.

Accordingly, in this instance, the appeal of the RNPR should have been added to the Provider's pending individual appeal under Case No. 19-2038 which, in addition to others, contained the **same** six issues addressed herein.[8] ***The Board directs the Representative to review Board Rules 4.6 and 6.3 for compliance to ensure duplicate individual appeals are not filed.*** *The Board also notes that the OH CDMS PRRB Module External User Manual at §§ 3.3.4.3 and 3.3.4.3.1 describes how a determination may be added to an existing individual appeal in OH CDMS using the Case Correspondence Drop-Down Menu.*[9]

* * * * *

In conclusion, the Board ***dismisses*** the six issues appealed from the RNPR in Case No. 21-0408 as the Provider does not have the right to appeal the RNPR at issue for these issues. Further, the Board necessarily ***denies*** the Provider's previous requests to transfer these issues to Case Nos. 19-2051GC, 19-2048GC, 19-2049GC, 19-2050GC, 19-2052GC and 19-2053GC. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 21-0408 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/31/2021

X Clayton J. Nix

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

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

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[8] The Board notes that the six duplicate issues were previously transferred from the *original* NPR appeal (Case No. 19-2038) to CIRP groups on September 24, 2019.
[9] OH CDMS PRRB Module External User Manual, Version 1.0, at 64-65 (Aug. 22, 2018) (PDF copy available at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Determination***
Sutter Medical Center of Santa Rosa (05-0291), FYE 12/31/2011
PRRB Case No. 21-0170

Dear Mr. Jaeger and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On September 23, 219, the Medicare Contractor ("MAC") issued the Notice of Reopening in which it advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio."

On June 1, 2020, the MAC issued the Notice of Amount of Corrected Reimbursement ("RNPR").[1]

On November 4, 2020, Sutter Health ("Sutter") filed the individual appeal from the RNPR to which the Board assigned Case No. 21-0170. The RNPR appeal included six issues:

DSH SSI Ratio – Inaccurate Data (SSI Accuracy)
DSH SSI Ratio Part C Days (SSI Fr. Part C days)
DSH SSI Ratio Part A Days (SSI Fr. Part A days)
DSH SSI Ratio MMA Section 951 (SSI MMA Section 951)
DSH Medicaid Dual Eligible Part C Days (M'caid Fr. Part C days)
DSH Medicaid Dual Eligible Part A Days (M'caid Fr. Part A days)

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[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").

For all six issues, the Provider referenced Audit Adjustment #4 from the RNPR. The Audit Adjustment indicates it was issued "[t]o adjust SSI percentage and allowable Disproportionate Share Adjustment based on the latest CMS Letter of SSI Percentage Realignment."

Board Determination

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

Relevant Regulations – RNPRs

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

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

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

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

The Board finds that it does not have jurisdiction over the six issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment

request, and did not specifically adjust these issues. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[2] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Notice of Reopening, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[3] The realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis (*e.g*., does not change data on Part A or Part C days) since CMS does not rerun the data matching process in order to effectuate a realignment. Indeed, to this end, CMS' realignment policy is that the provider must accept the realigned SSI percentage.[4] Since the only matter specifically revised in the RNPR was to realign the SSI percentage from federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the the SSI Accuracy, SSI Fr. Part C days, SSI Fr. Part A days, SSI MMA Section 951, M'caid Fr. Part C days, or M'caid Fr. Part A days issues in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[5]

In conclusion, the Board ***dismisses*** the six issues appealed from the RNPR in Case No. 21-0488 as the Provider does not have the right to appeal the RNPR at issue for these issues. Further, the Board necessarily ***denies*** the Provider's requests to transfer four of these issues to Case Nos. 17-1076GC, 17-1161GC, 17-1071GC and 17-2198GC. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 21-0170 and removes it from the Board's docket.

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[2] 42 C.F.R. § 405.1889(b)(1).
[3] CMS does not re-run the data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).
[4] *See supra* note 3 (quoting CMS realignment policy at 70 Fed. Reg. at 47439).
[5] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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

FOR THE BOARD:

3/31/2021

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

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

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RE: ***Jurisdictional Determination***
Sutter Medical Center - Sacramento (05-0108), FYE 12/31/2011
PRRB Case No. 21-0405

Dear Mr. Jaeger and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On December 20, 2018, the Medicare Contractor ("MAC") issued the Notice of Reopening in which it advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio."

On July 14, 2020, the MAC issued the Notice of Amount of Corrected Reimbursement ("RNPR").[1]

On December 20, 2020, Sutter Health ("Sutter") filed the individual appeal from the RNPR to which the Board assigned Case No. 20-0405.[2] The RNPR appeal included six issues:

DSH SSI Ratio – Inaccurate Data (SSI Accuracy)
Medicare DSH SSI Ratio Part C Days (SSI Fr. Part C days)
Medicare DSH SSI Ratio Part A Days (SSI Fr. Part A days)
Medicare DSH SSI Ratio MMA Section 951 (SSI MMA Section 951)
Medicare DSH Medicaid Dual Eligible Part C Days (M'caid Fr. Part C days)

[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[2] Sutter Health filed a separate appeal for the RNPR rather than using the "Add Determination" case action to add it to the pending appeal for the Provider's FYE 12/31/2011 pending NPR based appeal (Case No. 18-1321).

Medicare DSH Medicaid Dual Eligible Part A Days (M'caid Fr. Part A days)

For all six issues, the Provider referenced Audit Adjustment #4 from the RNPR. The Audit Adjustment is a generic adjustment issued "[t]o revise the SSI and DSH percentage." The cover page to the RNPR references back to the reopening by stating, in pertinent part: "This is an addendum to the prior settlement dated May 25, 2016 Reason for Reopening: . . . To adjust the SSI ratio used to calculate the providers [DSH] adjustment based on data from the hospital's actual cost reporting period rather than the federal fiscal year . . . ."

Board Determination

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

Relevant Regulations – RNPRs

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

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

The Board finds that it does not have jurisdiction over the six issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request, and did not specifically adjust these issues. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Notice of Reopening, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[4] The realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis (*e.g.*, does not change data on either Part A or Part C days) since CMS does not rerun the data matching process in order to effectuate a realignment. Indeed, to this end, CMS' stated realignment policy is that the provider must accept the realigned SSI percentage.[5] Since the only matter specifically revised in the RNPR was to realign the SSI percentage from federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the the SSI Accuracy, SSI Fr. Part C days, SSI Fr. Part A days, SSI MMA Section 951, M'caid Fr. Part C days, or M'caid Fr. Part A days issues in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[6]

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[3] 42 C.F.R. § 405.1889(b)(1).

[4] CMS does not re-run the data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[5] *See supra* note 4 (quoting CMS realignment policy at 70 Fed. Reg. at 47439).

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

In addition, the Board directs the Representative's attention to Board Rule 6.3, which gives guidance on multiple determinations appealed by a Provider for the same fiscal year end. The Rule states:

> **6.3 Adding a New Determination to an Individual Case**
>
> **6.3.1 Request and Supporting Documentation**
>
> For individual appeals, an appeal may be for only one cost reporting period. *If multiple final determinations were issued* ***on different dates*** *for the cost reporting period being appealed(e.g., NPR, revised NPRs, exception request denials, etc.), providers* ***must*** *timely request to add the subsequent determination to its pending appeal for that cost reporting period.*" Reference Model Form A – Individual Appeal Request (Appendix A) for all required data fields and supporting documentation.[7]

Similarly, Board Rule 4.6 prohibits "Duplicate Filings":

> **4.6 No Duplicate Filings**
>
> **4.6.1 No Duplicate Filings Same Issue from One Determination**
> A provider may not appeal an issue from a single final determination in more than one appeal.
>
> **4.6.2 Same Issue from Multiple Determinations**
> Appeals of the same issue from distinct determinations must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals.
>
> **4.6.3 Issue Previously Dismissed or Withdrawn**
> Once an issue is dismissed or withdrawn, the issue may not be appealed in any other case.

Accordingly, in this instance, the appeal of the RNPR should have been added to the Provider's pending individual appeal under Case No. 18-1321 which, in addition to others, contained the **same** six issues addressed herein.[8] ***The Board directs the Representative to review Board Rules 4.6 and 6.3 and come into compliance with them to ensure duplicate individual appeals are not filed. The Board directs the Representative to review Board Rules 4.6 and 6.3 for compliance to ensure duplicate individual appeals are not filed.*** *The Board also notes that the OH CDMS PRRB Module External User Manual at §§ 3.3.4.3 and 3.3.4.3.1 describes how a*

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[7] Board Rules. (Aug. 29, 2018)
[8] The Board notes that the six duplicate issues were previously transferred from the *original* NPR appeal (Case No. 18-1321) to CIRP groups on September 24, 2018.

determination may be added to an existing individual appeal in OH CDMS using the Case Correspondence Drop-Down Menu.[9]

* * * * *

In conclusion, the Board ***dismisses*** the six issues appealed from the RNPR in Case No. 21-0405 as the Provider does not have the right to appeal the RNPR at issue for these issues. Further, the Board necessarily ***denies*** the Provider's requests to transfer four of these issues to Case Nos. 17-1076GC, 17-1161GC, 17-1071GC and 17-2198GC. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 21-0405 and removes it from the Board's docket.

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

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

FOR THE BOARD:

3/31/2021

X Clayton J. Nix

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

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

[9] OH CDMS PRRB Module External User Manual, Version 1.0, at 64-65 (Aug. 22, 2018) (PDF copy available at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Determination***
Alta Bates Medical Center (05-0305), FYE 12/31/2013
PRRB Case No. 21-0488

Dear Mr. Jaeger and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On September 5, 2019, the Medicare Contractor ("MAC") issued the Notice of Reopening in which it advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio."

On August 12, 2020, the MAC issued the Notice of Amount of Corrected Reimbursement ("RNPR").[1]

On January 13, 2021, Sutter Health ("Sutter") filed the individual appeal from the RNPR to which the Board assigned Case No. 20-0488.[2] The RNPR appeal included six issues:

DSH SSI Ratio – Inaccurate Data (SSI Accuracy)
DSH SSI Ratio Part C Days (SSI Fr. Part C days)
DSH SSI Ratio Part A Days (SSI Fr. Part A days)
DSH SSI Ratio MMA Section 951 (SSI MMA Section 951)

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[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[2] As discussed *infra*, Sutter Health ***improperly*** filed a separate appeal for the RNPR rather than using the "Add Determination" case action to add it to the pending appeal for the Provider's FYE 12/31/2013 pending NPR-based appeal (Case No. 19-2292).

DSH Medicaid Dual Eligible Part C Days (M'caid Fr. Part C days)
DSH Medicaid Dual Eligible Part A Days (M'caid Fr. Part A days)

For all six issues, the Provider referenced Audit Adjustment #4 for all six issues appealed from the RNPR. Audit Adjustment #4 is a adjustment issued "[t]o adjust the SSI% and the Disproportionate Share Amount based on the latest CMS Letter of SSI% Realignment." To this end, the cover page to the RNPR references back to the reopening by stating, in pertinent part: "This is an addendum to the prior settlement dated May 25, 2016 Reason for Reopening: . . . To adjust the SSI ratio used to calculate the providers [DSH] adjustment based on data from the hospital's actual cost reporting period rather than the federal fiscal year . . . ."

Board Determination

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

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

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

The Board finds that it does not have jurisdiction over the six issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request, and did not specifically adjust these issues. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Notice of Reopening, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year.[4] The realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis (*e.g*., does not change data on either Part A or Part C days) since CMS does not rerun the data matching process in order to effectuate a realignment. Indeed, to this end, CMS' stated realignment policy is that the provider must accept the realigned SSI percentage.[5] Since the only matter specifically revised in the RNPR was to realign the SSI percentage from federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the SSI Accuracy, SSI Fr. Part C days, SSI Fr. Part A days, SSI MMA Section 951, M'caid Fr. Part C days, or M'caid Fr. Part A days issues in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[6]

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[3] 42 C.F.R. § 405.1889(b)(1).

[4] CMS does not re-run the data match process when it issues a realigned SSI percentage. 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). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[5] *See supra* note 4 (quoting CMS realignment policy at 70 Fed. Reg. at 47439).

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

In addition, the Board directs the Representative's attention to Board Rule 6.3, which gives guidance on multiple determinations appealed by a Provider for the same fiscal year end. The Rule states:

> **6.3 Adding a New Determination to an Individual Case**
>
> **6.3.1 Request and Supporting Documentation**
>
> For individual appeals, an appeal may be for only one cost reporting period. *If multiple final determinations were issued* ***on different dates*** *for the cost reporting period being appealed (e.g., NPR, revised NPRs, exception request denials, etc.), providers* ***must*** *timely request to add the subsequent determination to its pending appeal for that cost reporting period.*" Reference Model Form A – Individual Appeal Request (Appendix A) for all required data fields and supporting documentation.[7]

Similarly, Board Rule 4.6 prohibits "Duplicate Filings":

> **4.6 No Duplicate Filings**
>
> **4.6.1 No Duplicate Filings Same Issue from One Determination**
> A provider may not appeal an issue from a single final determination in more than one appeal.
>
> **4.6.2 Same Issue from Multiple Determinations**
> Appeals of the same issue from distinct determinations must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals.
>
> **4.6.3 Issue Previously Dismissed or Withdrawn**
> Once an issue is dismissed or withdrawn, the issue may not be appealed in any other case.

Accordingly, in this instance, the appeal of the RNPR should have been added to the Provider's pending individual appeal under Case No. 19-2292 which, in addition to others, contained the **<u>same</u>** six issues addressed herein.[8] ***The Board directs the Representative to review Board Rules 4.6 and 6.3 for compliance to ensure duplicate individual appeals are not filed.*** *The Board also notes that the OH CDMS PRRB Module External User Manual at §§ 3.3.4.3 and*

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[7] Board Rules. (Aug. 29, 2018)
[8] The Board notes that the six duplicate issues were previously transferred from the original NPR appeal (Case No. 19-2292) to CIRP groups on October 11, 2019.

3.3.4.3.1 describes how a determination may be added to an existing individual appeal in OH CDMS using the Case Correspondence Drop-Down Menu.[9]

* * * * *

In conclusion, the Board ***dismisses*** the six issues appealed from the RNPR in Case No. 21-0488 as the Provider does not have the right to appeal the RNPR at issue for these issues. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 21-0488 and removes it from the Board's docket.

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

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

FOR THE BOARD:

3/31/2021

X Clayton J. Nix

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

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

[9] OH CDMS PRRB Module External User Manual, Version 1.0, at 64-65 (Aug. 22, 2018) (PDF copy available at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing).