DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Ms. Kimberly Jones
HCA Healthcare
2000 Health Park Dr., 2-North
Brentwood, TN 37027

RE: ***Dismissal of Appeal***
Palms West Hospital (Prov. No. Provider No. 10-0269)
FYE 5/31/2018
Case No. 22-0669

Dear Ms. Jones:

On February 6, 2022, the Provider filed the above-captioned appeal with the Provider Reimbursement Review Board ("Board") using the Office of Hearings Case and Document Management System ("OH CDMS"). As set forth below the Board is dismissing the appeal for failure to comply with the appeal filing requirements in 42 C.F.R. § 405.1835(b).

FACTS:

On February 6, 2022, the Provider filed this appeal using OH CDMS. The Provider indicated on the Determination page, that the appeal is based on the Notice of Program Reimbursement ("NPR") dated August 13, 2021 for the fiscal year ending ("FYE") May 31, 2018. However, the Provider did not include a copy of the final determination in dispute. Rather, in lieu of uploading the final determination, the Provider uploaded the audit adjustment pages dated August 12, 2021 (which were also uploaded in the proper space designated specifically for audit adjustment pages). Both the PDF document uploaded as the "final determination document" and the PDF document uploaded as the "audit adjustment support documentation" are entitled "100269 05312018 NPR Adj" which indicates that it contained the audit adjustment pages.

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. In this regard, 42 C.F.R. § 405.1835(b)(3) addresses the contents of a request for Board hearing and requires the submission of:

> *A copy of the final contractor . . . determination under appeal* and any other documentary evidence the provider considers necessary

> to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.[1]

Further, § 405.1835(b) specifies that, "[i]f 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."[2] Similarly, Board Rule 6.1.1 Request and Supporting Documentation states:

> To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. *The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d) as relevant.*[3]

CONCLUSION:

42 C.F.R. § 405.1835(a) gives a provider the "right to hearing on [a] final contractor determination." Because the Provider's appeal request did not include the actual final determination being appealed as required by 42 C.F.R. § 405.1835(b)(3), the Board has determined that the appeal request does not meet the filing requirements set forth in the 42 C.F.R. § 405.1835(b) and the Board Rules.[4] Accordingly, the Board is exercising is discretion under § 405.1835(b) to dismiss Case No. 22-0669, in its entirety, and removes it from the Board's docket.

Board Members:

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

FOR THE BOARD:

3/1/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc.

[1] (Emphasis added.)
[2] (Emphasis added.)
[3] (Emphasis added.)
[4] Audit adjustment pages are not a final determination and, to the extent that they are associated with a final determination, they may be issued days if not weeks prior to that final determination. The Board cannot determine whether an appeal was properly or timely filed without a copy of the final determination being appealed.

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Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave., NW
Washington, DC 20006

RE: ***Request for Reconsideration of Jurisdictional Dismissal***
Rochester General Hospital (Prov. No. 33-0125)
FYE 12/31/2015
Case No. 20-1881

Dear Ms. Webster:

In a jurisdictional determination issued on April 16, 2021 the Provider Reimbursement Review Board ("Board") dismissed the above-captioned appeal. The ***sole*** issue in the appeal was the inpatient rehabilitation facility ("IRF") outlier payments. The Board has treated the request as a motion for reinstatement and set forth below is the Board **denial** of the Provider's motion.

Background

The Medicare statute at 42 U.S.C. § 1395ww(j) directs CMS to set Medicare rates for inpatient rehabilitation services through a two-step process. The first step involves establishing a standardized reimbursement rate for each discharges patient based on the average estimated cost of inpatient operating facilities and treating patients for the upcoming year. The second step takes place after the fiscal year has ended, when CMS adjusts the standardized rates to reflect the particular circumstances of each hospital for that year. These adjustments authorized in the statute include four specific adjustments for price increases in the relevant market, outlier adjustments, wage index adjustments and case mix adjustments.

In the instant appeal, Rochester General Hospital sought Board review of one of the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and calculating Rochester General's final payment. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the outlier payment adjustment, the Board concluded that it lacked jurisdiction to hear Rochester General's appeal of the IRF outlier reconciliation issue. In support of this finding, the Board cited to the decision of the U.S. Court of Appeals for the District of Columbia ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*")[1] and noted that it is controlling precedent because the Provider could bring suit in the D.C. Circuit.

[1] 891 F.3d 1062 (D.C. Cir. 2018), *affirming* 206 F. Supp. 3d 93 (D.D.C. 2016).

In a letter dated June 14, 2021, the Provider requested that the Board reconsider its April 16, 2021 decision dismissing for lack of jurisdiction the Provider's appeal of the revisions of the outlier claims payments made to the Provider's inpatient rehabilitation facility ("IRF") and reinstate the Provider's appeal because the Board improperly issued its *sua sponte* decision without affording the Provider an opportunity to be heard as to why jurisdiction is proper over this appeal.

The Board responded in a letter dated July 26, 2021, deferring action on the Provider's request, and issued a Scheduling Order to the parties to further develop the motion for reinstatement and reconsideration. In this regard, the Provider submitted a brief in support of the request for reconsideration on August 25, 2021. The Medicare Contractor submitted a response to the Provider's brief on September 24, 2021. Finally, the Provider submitted an optional responsive brief on October 8, 2021.

Provider's Brief in Support of Request for Reconsideration

The Provider contends that the Board was incorrect in: (a) concluding that the statute governing IRFs at 42 U.S.C. § 1395ww(j)(8) precludes administrative and judicial review of the Provider's appeal; and (b) relying on the D.C Circuit's decision in *Mercy* in support of that conclusion.

The Provider contends that the Medicare Contractor's offline retroactive revision of the Provider's specific IRF outlier claim payments through the Medicare cost report is not the kind of determination that is precluded from review under the plain terms of the governing statute. In support of this contention, the Provider argues that:

1. The statute only prevents review of the "establishment" of either the IRF prospective payment rates or the IRF outlier payment, and the Medicare Contractor's retroactive, after-the-fact, reprocessing of IRF outlier claims payments effectuated through the challenged cost report adjustment is far from an "establishment" of those IRF payments.

2. The Board's reliance on the *Mercy* decision is misplaced and does not resolve the question of jurisdiction in the Provider's appeal because the IRF outlier claims payment revisions at issue in this case are *materially* different from the low-income percentage ("LIP") payment adjustment to IRF payment rates at issue there.[2]

Accordingly, the Provider asserts that the Board's jurisdictional dismissal in this case is incorrect and should be reversed. In this regard, the Provider notes that it is appealing an improper adjustment made on its cost report reflecting the impact of the IRF outlier claims revisions, and otherwise meets the requirements for Board jurisdiction under 42 C.F.R. § 405.1835.

The Provider argues that, as an initial matter, the Board generally has jurisdiction over challenges to cost report determinations such as the one made here. Because the agency chose to

[2] Brief in Support of Provider's Request for Reconsideration of Jurisdictional Dismissal at 1-2.

make these offline claims adjustments through the Provider's cost report, the Provider maintains that it properly challenged these determinations through a cost report appeal as authorized by 42 U.S.C. § 1395oo.[3]

More specifically, the Provider maintains that the plain language of the IRF statute does not expressly or unambiguously preclude review of revisions to IRF outlier claims payments. Congress granted providers of services – including rehabilitation facilities – a broad right to obtain judicial and administrative review of Medicare reimbursement determinations. The Provider argues that, when Congress adopted the IRF prospective payment system, it adopted a *limited* preclusion of review provision. The Provider's maintain this limited preclusion applies only to "the establishment of" limited components of the methodology used to determine total payments, including the "prospective payment rates" and "outlier and special payments."[4]

In support, the Provider sets forth two primary arguments. First, the Provider asserts that it is not challenging the "establishment" of the outlier payment, which involves the annual calculation of a fixed-loss threshold based on a prospective estimate of the amount that will produce IRF outlier payments of 3 percent of the total IRF prospective payment amounts before outliers are paid. Rather, the Provider maintains that it is challenging the retroactive revision of outlier claims by the Medicare Contractor, long after the establishment of the annual calculations and well after the outlier claims were actually paid. The Provider maintains that the offline, retroactive revision of payments made on claims-by claims basis is far from the "establishment" of the outlier payment.[5]

In this regard, the Provider argues that, in recalculating an IRF's outlier payments, individual outlier patient claims are revised and the total amount of the hospital's outlier payment is reported on a particular line of the cost report. Similarly, the aggregate reductions to the outlier payment for recalculated claims and the time value of money are also reflected, but not actually calculated, on the cost report. Because the agency chose to make these offline adjustments on the cost report, the Provider's only option for challenging these determinations is through a cost report appeal. Retrospective recalculation of outlier claims, using cost and charge data specific to each hospital cost reporting period, is not a part of the "establishment of" the outlier payment for which section 1395ww(j)(8) bars the review generally available under section 1395oo(f)(1), and therefore cannot be used to deny the Provider of jurisdiction over the appeal. The presumption in favor of review, when combined with the clear fact that the revised claims payments at issue here are not part of the "establishment" of the outlier payments, means the Board should not apply section 1395ww(j)(8) to deny jurisdiction over the Provider's appeal.[6]

Finally, the Provider argues that, even if the statutory preclusion provision were to cover the Medicare Contractor's revisions to the claims payments, the Board would still have jurisdiction because the Medicare Contractor's action is *ultra vires*. In support, the Provider points to *Fresno*

[3] *Id.* at 7.
[4] *Id.* at 8.
[5] *Id.* at 9.
[6] *Id.* at 9-10.

Cmty. Hosp. & Med. Ctr. v. Azar ("*Fresno Community*")[7] that held that an agency action is open to judicial review, even in the face of an applicable preclusion statute, when it "patently misconstrues a statute, disregards a specific and unambiguous statutory directive, or violates a specific command of a statute."'[8] The Provider argues that, to the extent that the outlier claims payments were revised outside the requisite windows for reopening those claims, the Medicare Contractor patently violated the Medicare statute by failing (1) to provide the necessary notice to the beneficiary, (2) to file within the four-year timeframe for reopening claims determinations, and (3) to hold the Provider harmless because it was not at fault for any alleged overpayment. The Board, therefore, has jurisdiction over the appeal, regardless of the statutory preclusion provision.[9]

Second, the Provider argues that the D.C. Circuit's decision in *Mercy* does not speak to jurisdiction over the Provider's appeal in the present case. The Provider maintains that, in that case, the D.C. Circuit concluded that a challenge to the agency's across-the-Board treatment of Part C Days in the LIP payment adjustment for fiscal years prior to 2004, applied to all eligible hospitals in the same manner, was barred by the provision precluding review of the establishment of "prospective payment rates" because the LIP payment adjustment is "inextricably intertwined" with the calculation of the prospective payment rates. Accordingly, the Providers maintain that *Mercy* did not conclude that all aspects of payments to IRFs were precluded from review, but instead that that one adjustment made on a uniform, nationwide basis to the prospective rates was part of the "establishment" of those rates and therefore precluded from review.[10]

Finally, the Provider contends that, unlike the prospective payment rates at issue in *Mercy*, the IRF outlier payments at issue are not precluded from review. In support, the Provider maintains that, in retrospectively reconciling the hospital's outlier payments, the Secretary reprocesses each of a hospital's outlier claims through the Medicare claims processing system in order to determine the hospital's aggregate outlier claims payment revision amount in order to then report that on the cost report. As a result, the Provider contends that the revisions to claims payments at issue here are not part of a prospective payment rate calculation, and are not enumerated in the statute as adjustments to be made to prospective payment rates. The Provider concludes that the outlier claims payments at issue are distinct from, and cannot be considered "inextricably intertwined" with, the "establishment" of the outlier payment.[11]

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[7] 370 F. Supp. 3d 139 (D.D.C. 2019)
[8] Brief in Support of Provider's Request for Reconsideration of Jurisdictional Dismissal at 10 (quoting 370 F. Supp. 3d at 152 (quoting *Hunter v. Fed. Energy Reg. Comm'n*, 569 F. Supp. 2d 12, 16 (D.D.C. 2008)).
[9] *Id.* at 10-11.
[10] *Id.* at 11-12.
[11] *Id.* at 12.

Medicare Contractor's Response to Provider's Request for Reconsideration

The Medicare Contractor states that the Provider has asked the Board to reconsider a prior substantive jurisdictional decision but fails to explain the procedural mechanism for a motion to reconsider as such a motion is not contemplated by either the Board's rules or the applicable regulations. The Provider has had several opportunities to appeal the Board's jurisdictional decision: first to the Administrator or, alternatively in the District Court and its brief fails to explain why either of those two options were not pursued.[12]

The Medicare Contractor notes that the Provider's motion is styled as a motion to reconsider. The motion sets forth the reasons the Provider contends the Board erred in dismissing the case, and as relief, asks that the case be reinstated. However, the Medicare Contractor notes that the Board Rules do not allow motions to reconsider and that, if a party is dissatisfied with a Board ruling, their recourse is with the Administrator or the district courts. In this regard, 42 C.F.R. § 405.1840 specifically provides that a Board decision is ***final*** unless reversed by the Administrator. As such, the Medicare Contractor maintains that the Provider's recourse, when it disagreed with the Board's decision, was to request review by the Administrator, not reconsideration by the Board.[13]

Regarding the substance of the Board's jurisdictional determination, the Medicare Contractor argues that 42 U.S.C. § 1395ww(j)(8) unequivocally precludes "administrative or judicial review" of the establishment of "outlier and special payments." The Medicare Contractor explains that the rates for inpatient rehabilitation services are established through a two-step process:

Step 1 – A standardized reimbursement rate is established for each discharge. That rate is based on the average estimated cost of inpatient operating facilities and patient treatment for the upcoming year. Because the rate is determined in advance of the upcoming year it is prospective.

Step 2 – After the fiscal year has ended, the second step begins. At that point, CMS adjusts the standardized rates to reflect the particular circumstances of individual providers during the year. Among the "step two" adjustments to a provider's prospective payment rates are outlier adjustments.[14]

The Medicare Contractor asserts that, in *Mercy*, the D.C. Circuit held that the calculation of prospective payment rates as set forth in § 1395ww(j)(8)(B) means the "ultimate payment rate,

[12] MAC Response in Opposition to the Provider's Request for Reconsideration of Jurisdictional Dismissal and Reinstatement of the Case at 1.
[13] *Id.* at 4.
[14] *Id.* at 5.

after the adjustments are factored in"[15] and that, as a result, review of each of the steps is otherwise precluded.[16]

The Medicare Contractor argues that the Medicare Contractor's "offline" revision of outlier claims, otherwise known as reconciliation of the Provider's outlier claims, is part of the step two adjustment to the Provider's payment. Outlier payments are paid prospectively, at the end of the year they are reconciled. That reconciliation process, which is detailed in the Provider Reimbursement Manual, is part of a provider's prospective payment, specifically the adjustments to such prospective payment. The Board correctly noted that the outlier reconciliation is part of the step two process and correctly found that it lacks jurisdiction over the appeal.[17]

The Medicare Contractor goes on to argue that the Medicare Contractor's action is not *ultra vires*. The Medicare Contractor states that the D.C. District Court held in *Fresno Community* that, under the *ultra vires* doctrine (on which the Provider relies), "a bar on judicial review extends 'no further than the Secretary's authority to make the challenged determination.'"[18] The Medicare Contractor asserts that the Provider is not challenging the Medicare Contractor's authority to make its determinations, but rather that it is challenging the determination itself. The D.C. District Court in *Fresno Community* held that alleging an action was in violation of a statute does not rise to the level of alleging an *ultra vires* act.[19]

Provider's Response to Medicare Contractor's Opposition to Reconsideration of Jurisdiction Dismissal

The Provider asserts that the Medicare Contractor's argument that the Board may not consider a reconsideration request is wholly without merit. The Provider states that 42 C.F.R. § 405.1840 specifically states that "[a] final Board decision under paragraphs (c)(2) and (c)(3) of this section may be reopened and revised by the Board in accordance with § 405.1885 through 405.1889 of this subpart." In this regard, § 405.1885 provides that reopening request is timely if it is received, within 3 years, by the "reviewing entity", which is defined to include the Board. In any event, the Board has already rejected the Medicare Contractor's argument by specifically invoking the reopening regulations, allowing the parties to further develop the Provider's request, and treating the Provider's reconsideration request as a "Request for Reinstatement."[20]

The Provider reasserts that the Medicare Contractor's revision of the Provider's outlier claims payments is indeed, *ultra vires*. The Provider maintains that the *Fresno Community* court did *not* hold that an alleged statutory violation was insufficient to invoke the *ultra vires* doctrine and that, in fact, the court stated the opposite. The Provider points to three cases where the D.C. Circuit has also found that agency actions were *ultra vires* and proceeded to review such actions despite

[15] *Id.* at 5 (quoting *Mercy* at 1066 (quoting the D.C. District Court decision, 206 F. Supp. 3d at 98).
[16] *Id.*
[17] *Id.* at 5-6.
[18] *Id.* at 6 (quoting *Fresno Community* at 151).
[19] *Id.* at 6.
[20] Provider's Response to Medicare Contractor's Opposition to Reconsideration of Jurisdictional Dismissal at 2-3.

review preclusion provisions. Here, despite what the Medicare Contractor inaccurately claims, the Provider *is* challenging the Medicare Contractor's statutory authority to make its determinations.[21]

The Provider goes on to argue that outlier payments are *not* adjustments to a provider's prospective payment rates. To the contrary, outlier payments are *case-by-case claims payments* that are paid based upon established thresholds, *not* retrospective adjustments to base prospective payment rates. Outlier payments are made to hospitals on a rolling, claim-by claim basis throughout the course of a year, and those payments "generally represent final payment." Thus, outlier payments are not "step two" adjustments, nor are they part of the "establishment of" the "outlier" payments for which § 1395ww(j)(8) bars review that is generally available under § 1395oo(f)(1).[22]

Board's Decision

The Provider has requested that the Board reconsider its jurisdictional dismissal and reinstate the Provider's appeal.[23] In considering the request, the Board reviewed the following regulations and Board Rules and determined that the Provider's request was a motion for reinstatement under Board Rule 47.1:

1. 42 C.F.R. § 405.1840 which, in pertinent part, states:

> (a) *General rules*. (1) After a request for a Board hearing is filed under § 405.1835 or § 405.1837 of this part, the Board must determine **in accordance with paragraph (b) of this section**, whether or not it has jurisdiction to grant a hearing on each of the specific matters at issue in the hearing request. . . .
>
> (b) *Criteria*. Except with respect to the amount in controversy requirement, **the jurisdiction of the Board to grant a hearing** must be determined separately for each specific matter at issue in each contractor or Secretary determination for each cost reporting period under appeal. The Board has **jurisdiction to grant a hearing** over a specific matter at issue in an appeal **only if the provider has a right to a Board hearing** as a single provider appeal under § 405.1835 of this subpart or as part of a group appeal under § 405.1837 of this subpart, as applicable. **Certain matters at issue are removed from jurisdiction of the Board**. These matters include, but are not necessarily limited to, the following:

[21] *Id.* at 3-4 (emphasis in original).
[22] Provider's Response to Medicare Contractor's Opposition to Reconsideration of Jurisdictional Dismissal at 3-4. (Emphasis included.)
[23] The Provider filed its request on June 14, 2021 (59 days after the Board's issuance of its jurisdictional determination on April 16, 2021). It is unclear whether the Provider appealed the Board's jurisdictional determination to the Administrator and/or district court.

> (1) A finding in a contractor determination that expenses incurred for certain items or services furnished by a provider to an individual are not payable under title XVIII of the Act because those items or services are excluded from coverage under section 1862 of the Act and part 411 of the regulations. . . .
>
> (2) Certain matters affecting payments to hospitals under the prospective payment system, as provided in section 1886(d)(7) of the Act and § 405.1804 of this subpart.
>
> (c) *Board's jurisdictional findings and jurisdictional dismissal decisions*. . . .
>
> (2) Except as provided in §§ 405.1836(e)(1) and 405.1842(f)(2)(i), where the Board determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a dismissal decision dismissing the appeal for lack of Board jurisdiction. The decision by the Board must include specific findings of fact and conclusions of law explaining the Board's determination that it lacks jurisdiction to grant a hearing on each matter at issue in the appeal. A copy of the Board's decision must be sent promptly to each party to the appeal (as described in § 405.1843).
>
> (3) A dismissal decision by the Board under paragraph (c)(2) of this section is final and binding on the parties unless the decision is reversed, affirmed, modified or remanded by the Administrator under § 405.1875(a)(2)(ii) and § 405.1875(e) or § 405.1875(f) of this subpart, no later than 60 days after the date of receipt by the provider of the Board's decision. **The Board decision is <u>inoperative</u> during the 60-day period for review of the decision by the Administrator**, or in the event the Administrator reverses, affirms, modifies or remands that decision within that period. **A final Board decision under paragraphs (c)(2) and (c)(3) of this section <u>may be reopened and revised</u> by the Board in accordance with §§ 405.1885 through 405.1889 of this subpart**.[24]

[24] (Bold and underline emphasis added.) *See also* 42 C.F.R. § 405.1845(e) (stating "(e) *Hearings.* The Board may conduct **a hearing** and issue a hearing decision (as described in §405.1871 of this subpart) on a specific matter at issue in an appeal, **<u>provided it finds jurisdiction</u> over the matter at issue in accordance with §405.1840 of this part** and determines it has the legal authority to fully resolve the issue (as described in §405.1867 of this subpart)." (bold emphasis added)); Board Rule 4.1 (stating "*The Board **will dismiss** appeals that fail to meet* the timely filing requirements and/or *jurisdictional requirements*. . . . The Board may review jurisdiction on its own motion at any time." (emphasis added)).

2. Board Rule 7.2

7.2 Issue Related Information

7.2.1 General Information
The following information and supporting documentation *must be submitted for each issue raised in the appeal request.*

- An issue title and a concise issue statement describing:
  - o the adjustment, including the adjustment number,
  - o the controlling authority,
  - o why the adjustment is incorrect,
  - o how the payment should be determined differently,
  - o the reimbursement effect, and
  - o *the basis for jurisdiction before the PRRB.*
- A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.
- A calculation or other support for the reimbursement effect noted in the issue statement.
- Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4.

7.2.2. Additional Information
Providers must submit additional information not specifically addressed above *in order to support jurisdiction* or appropriate claim for the appealed issue(s).

Example: Revised NPR workpapers and applicable cost report worksheets to document that the issue under appeal was specifically adjusted.[25]

3. Board Rule 47.1

47.1 Motion for Reinstatement:
A provider may request reinstatement of an issue(s) or case within three years of the date of the Board' decision to dismiss the issue(s)/case, or if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the

[25] (Underline and italics emphasis added.) This Rule is based on 42 C.F.R. § 405.1835(a)-(b) and, in this regard, the Board notes that subsection (b)(1) states that an appeal request must include "[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." This necessarily includes whether the Board has substantive jurisdiction over the matter being appealed. *See* 42 C.F.R. § 405.1840(b).

> issue(s) (see *42 C.F.R. § 405.1885 addressing reopening of Board decisions*). *The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement* (see Rule 44 governing motions). The Board will not reinstate an issue(s)/case if the provider was at fault.[26]

The Board reiterates the following observations and findings made in its July 26, 2021 letter:

- The Provider's July 17, 2020 appeal request did not address the Board's substantive jurisdiction over the sole issue in this case concerning IRF IPPS outliers *notwithstanding* guidance in Board Rule 7.2 and 42 C.F.R. § 405.1835(b)(1) and 405.1840, and the fact that certain aspects of the IRF IPPS, including "outlier and other special payments under paragraph (4),"[27] are excluded from administrative and judicial review pursuant to 42 U.S.C. § 1395ww(j)(8).[28]

- More than 2 years prior to the Provider's filing of its appeal on July 17, 2020, the D.C. Circuit Court of Appeals *broadly* applied this statutory provision in *Mercy Hospital* which the Board discussed (and relied on) in its dismissal. Following the issuance of *Mercy Hospital*, over 200 cases involving the IRF IPPS adjustment factor known as LIP (that was the subject of *Mercy Hospital*) were either withdrawn by Provider representatives or dismissed by the Board based on *Mercy Hospital*'s broad application of 42 U.S.C. § 1395ww(j)(8).[29]

- The Provider admitted that its request for reconsideration and reinstatement was incomplete by requesting the opportunity to submit further briefing on the merits of its contention that the Board erred in dismissing this appeal. (To this end, the Board issued a Scheduling Order to allow the Provider an opportunity to rehabilitate and supplement its request/motion in compliance with Board Rule 47.1 and an opportunity for the Medicare Contractor to respond to the supplemented request/motion.)

In its motion for reinstatement, the Provider alleged that "the Board improperly issued its *sua sponte* decision without affording the Provider an opportunity to be heard as to why jurisdiction

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[26] (Underline and italics emphasis added.) *See also* 42 C.F.R. § 405.1885 (entitled, in pertinent part, "Reopening a . . . reviewing entity decision" and stating in subsection (a) that "a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific findings on matters at issue in a determination or decision . . . by the reviewing entity that made the decision (as described in paragraph (c) of this section).")

[27] 42 U.S.C. § 1395ww(j)(8)(C).

[28] The Provider's appeal request contains a detailed issue statement that includes references to 42 U.S.C. § 1395ww(j)(4) and discusses the IRF "outlier statute." However, it did not discuss 42 U.S.C. § 1395ww(j)(8) notwithstanding the requirement in 42 C.F.R. § 1835(b)(1) that its appeal request must "demonstrate[e] that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section . . . ." In this regard, 42 C.F.R. § 405.1840(b) notes that a right to hearing is dependent upon substantive jurisdiction and 42 C.F.R. § 405.1835(b) allows the Board to dismiss for failure to meet the content requirement therein.

[29] The Board takes administrative notice that Provider's Representative was the designated representative in some of these dismissed cases.

is proper over this appeal."[30] The Provider did not address or expound on this argument in its supplemental briefing. Nonetheless, the Board disagrees and notes that the above observations and findings in conjunction with the above regulations and Board Rules confirm that the Board did not err procedurally in issuing its jurisdictional determination dated April 16, 2021 that dismissed Case No. 20-1881.

In connection with the Provider's motion, the Board has reviewed the parties' supplemental briefing on the Provider's June 14, 2021 motion for reinstatement. Following the review, the Board finds that the Provider has not submitted any new or compelling arguments to alter or override the Board's initial determination to dismiss this case for lack of jurisdiction. The Provider's arguments (*e.g.*, the IRF PPS preclusion provision only applies to the establishment of the IRF outlier payments and that adjustments at issue were done retrospectively) were addressed by the D.C. Circuit in *Mercy*[31, 32] and the Board's reliance on *Mercy* as controlling precedent is set forth in the Board's decision.[33] Accordingly, the Board **denies** the Provider's request to

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[30] Request for Reconsideration of Jurisdictional Dismissal and Opportunity to Brief Jurisdiction (June 14, 2021) at 1.

[31] For example, the D.C. Circuit states:

> We think a careful read of the provision makes plain what 'prospective payment rate' means. Paragraph (3) boils down to the following: 'The Secretary shall determine a prospective payment rate ... based on the average payment ... [as] adjusted ....' The prospective payment rate is only based on, not equal to, the average payment; it is the average payment that is adjusted to *produce* the prospective payment rate. As the district court explained, 'there is simply no doubt that Congress used the term 'prospective payment rate' here in paragraph (3) to mean the *ultimate* payment rate, *after* the adjustments are factored in.' *Mercy Hosp.*, 206 F.Supp.3d at 98. We conclude that the statute defines "prospective payment rate" as the step-two, not the step-one, rate.

891 F.3d at 1066 (emphasis in original). Similarly, the D.C. Circuit states:

> A rate within a prospective payment system could easily be called a 'prospective payment rate' *despite relying on some variables, like the number of low-income patients served, that could not be filled in* ***until after the year ended***. Even if 'prospective' were not couched in the well-established context of prospective payment systems, Mercy Hospital would still be reading too much into a single word that Congress defined as part of the full phrase 'prospective payment rate' in paragraph (3).

Id. at 1071 (emphasis added). Also refer to Jurisdictional Determination (Apr. 16, 2021) at n.7 citing to and quoting 78 Fed. Reg. 47860, 47901 (Aug. 6, 2013) which highlights the parallels between LIP and outliers as adjustments to IRF PPS payments and the broad scope of the IRF statutory preclusion.

[32] The Board would never reach the Provider's *ultra vires* doctrine arguments as they are based on the misconception that the claim-by-claim determinations underlying the IRF outlier reconciliation were revised when the Medicare Contractor performed the outlier reconciliation as part of the FY 2015 cost report audit. Similar to other adjustments like IPPS DSH, the IRF outlier reconciliation process pertains to aggregate payment issues and is handled in the cost report audit process. *See Athens-Limestone Hosp. v. BC/BS of Alabama,* CMS Adm'r Dec. (Aug. 16, 1999), *modifying*, PRRB Dec. No. 1999-D51 (June 16, 1999); *Innovis Hospital v. Noridian Healthcare Solutions, LLC*, PRRB Dec. No. 2020-D15 (Aug. 14, 2020) (reviewing IPPS outlier reconciliation and discussing how the without fault provisions at 42 U.S.C. § 1395gg are applicable to individual claims but not to aggregate payment issues, such as IPPS outlier reconciliation, which are handled through the cost reporting process).

[33] As explained in the Board's April 16, 2021 jurisdictional determination at n.8, 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.

reinstate Case No. 20-1881 and, as such, **declines** to otherwise reopen and revise its jurisdictional determination dated April 16, 2021 that dismissed this case. The Board's jursidcitional decision dated April 16, 2021 dismissing this case remains final and this case remains closed.[34]

Review of this denial may be available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
Clayton J. Nix, Esq.
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FOR THE BOARD

3/11/2022

X Clayton J. Nix

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

cc: Danelle Decker, National Government Services, Inc.
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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).

[34] The motion for reinstatement, the parties' supplemental briefing, and the Board's ruling are part of the record in OH CDMS for this case.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
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Arcadia, CA 91006

RE: ***Rescission of Remand Under CMS Ruling CMS-1739-R and Case Dismissal***
Borgess Medical Center (Prov. No. 23-0117)
FYE: June 30, 2009
Case No. 14-0641

Dear Mr. Ravindran:

By letter dated January 7, 2021, the Provider Reimbursement Review Board ("Board" or "PRRB") issued a Remand of the Part C Days issues in this appeal. The Board has reviewed the record and hereby rescinds the Remand of the Part C Days issues in the appeal. In addition, the Board is also dismissing ***all*** remaining issues in this appeal for the reasons explained below.

Background:

On November 6, 2013, Quality Reimbursement Services ("QRS") established Case No. 14-0641 by filing an appeal request for Borgess Medical Center which contained the following issues:

- Issue 1 – DSH Supplemental Security Income ("SSI") Percentage (Provider Specific) - **Dismissed**
- Issue 2 – DSH SSI Percentage (Systemic Errors)
- Issue 3 – DSH Medicaid Eligible Days – **Withdrawn by Provider**
- Issue 4 – DSH SSI Fraction/Medicare Part C Days
- Issue 5 – DSH Medicaid Fraction/Medicare Part C Days
- Issue 6 – DSH Medicaid Eligible Labor Room Days – **Withdrawn by Provider**
- Issue 7 - DSH SSI Fraction/Dual Eligible Days
- Issue 8 – DSH Medicaid Fraction/Dual Eligible Days
- Issue 9 – Outlier Payments – Fixed Loss Threshold

The Medicaid Eligible Labor Room Days issue was withdrawn by the Provider on July 29, 2014, and the Medicaid Eligible Days were withdrawn by the Provider on July 14, 2015.

On January 7, 2021, the Board remanded the DSH SSI Fraction Part C Days and the DSH Medicaid Fraction Part C Days issues in the appeal to the Medicare Contractor pursuant to CMS Ruling 1739-R.

On March 17, 2021, the Board dismissed the DSH SSI Percentage (Provider Specific) issue from the appeal. This jurisdictional decision also addressed the remaining four issues in the appeal[1], and the Board specifically required the Provider to confer with Ascension Health and, following that conference, either:

(1) Transfer the remaining common DSH issues to CIRP groups; or

(2) Attest that there are no other related providers for this fiscal year, that either are, or could be pursuing the remaining issues.

The Provider was required to respond to the Board *within sixty (60) days from the date of the Board's letter* (*i.e.*, by May 17, 2021). However, the Provider never responded to that Board request.

Rescission of Remand Regarding Both Part C Days Issues

As part of this individual appeal request, QRS included the following certification:

> There may be other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on the same issues now being appealed for the cost reporting period that ends in the same calendar year covered in this request. Accordingly, the **Provider intends to transfer this Provider to an appropriate CIRP group appeal once this appeal of the NPR is established**. *See* 42 C.F.R. § 405.1835(b)(4)(i).[2]

However, there were no transfers effectuated.

Rules on Mandatory Common Issue Related Party (CIRP) Groups

By way of background, chain provider organizations are subject to the following requirement in 42 U.S.C. § 1395oo(f)(1):

> Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) ***must*** *be brought* by such providers *as a group* with respect to any matter involving an issue common to such providers.[3]

This statutory provision was implemented at 42 C.F.R. § 405.1837(b)(1)(i) and this regulation mandates the use of a CIRP group appeal where:

> *Two or more providers under common ownership or control* that wish to appeal to the Board a specific matter at issue that involved a question of

[1]The remaining issues were DSH SSI Percentage (Systemic Errors), DSH SSI Fraction Dual Eligible Days, DSH Medicaid Fraction Dual Eligible Days, and Outlier Payments Fixed Loss Threshold.
[2] (Bold emphasis added.)
[3] (Emphasis added).

> fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, *must bring the appeal as a group appeal*.

Further, 42 C.F.R. § 405.1835(b) address the "Contents of request for a Board hearing" and requires the following in paragraph (4) *when a provider is under common ownership or control*:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (1) 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.
>
> * * * *
>
> (4) **With respect to a provider under common ownership or control**, the name and address of its parent corporation, and a statement that –
>
> (i) To the best of the provider's knowledge, no other provider to which it is related by common ownership or control, has pending a request for a Board hearing pursuant to this section or pursuant to § 405.1837(b)(1) on any of the same issues contained in the provider's hearing request for a cost reporting period that ends within the same calendar year as the calendar year covered by the provider's hearing request; or
>
> (ii) Such a pending appeal(s) exists(s), and the provider name(s), provider number(s), and the case number(s) (if assigned), for such appeal(s).

42 C.F.R. § 405.1837(e)(1) and Board Rules further address the mandatory use of CIRP groups. First, 42 C.F.R. § 405.1837(e)(1) addresses full formation of groups:

> 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*.[4]

Further, the current Board Rules issued on August 29, 2018 states:

[4] (Emphasis added.)

12.3 Types of Groups

12.3.1 Mandatory Common Issue Related Part ("CIRP") Group

Providers under common ownership or control that with to appeal a specific matter that is common to the providers must bring the appeals a group appeal. *See* 42 C.F.R. § 405.1837(b).

****

Rule 19 – Full Formation of Groups

Reference 42 C.F.R. § 405.1837(e) regarding group appeal procedures pending full formation of the group and issuance of a Board decision.

19.2 – Mandatory (CIRP) Groups

Mandatory CIRP group appeals must contain all Providers eligible to join the group which intend to appeal the disputed common issue. The Board will determine that a CIRP group appeal is fully formed upon:

- Written notice from the Group Representative that the group is fully formed, or

- A Board order issued after the Group Representative has the opportunity to present evidence regarding whether any CIRP providers who have not received final determinations could potentially join the group. . . .[5]

Because the issue that was under appeal is a challenge to the validity of a regulation, it lends itself to the group appeal format and, as a result, the Board has consistently determined the Part C Days issue is a "common issue" that chain providers are required to pursue in CIRPs to the extent the other elements of 42 C.F.R. 405.1837(b)(1) are met.

Part C Days Issue:

The Part C Days issues in this appeal allege that Part C Days should be included in the Medicaid proxy of the DSH payment calculation, and not in the numerator or denominator of the Medicare proxy.[6]

[5] (Underline emphasis added).
[6] Provider's Individual Appeal Request Issue Statements for "Medicaid Fraction/Medicare Managed Care Part C Days" and "SSI Fraction/Medicare Managed Care Part C Days" issues.

This issue will be referred to as the Part C Days issue in the discussion below. The Part C Days issue challenges the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (the 2004 Rule) as promulgated in August 11, 2004 Federal Register.[7]

Importantly, the Board notes there was an Ascension Health CIRP Group for the Part C Days issue, which was closed on June 18, 2019, in response to the Providers' requests for EJR:

13-2615GC Ascension Health 2009 DSH Medicare/Medicaid Fraction Part C Days Group

In its Appeal Request, the Provider's representative confirmed that Borgess Medical Center was part of the Ascension Health Chain during FY 2009, the year at issue in this case. Therefore, pursuant to the regulations and Board Rules discussed above, Borgess Medical Center was required to be a participant in the group with the other CIRP providers appealing the Part C days issue for 2009, which has since been closed. To the extent Borgess Medical Center wished to pursue the Part C Days issue, QRS should have transferred the issue to Case No. 13-2615GC (Ascension Health 2009 DSH Medicare/Medicaid Fraction Part C Days Group) which remained opened from August 5, 2013 until June 18, 2019. The Board notes this CIRP group was certified complete by the Providers Representative and, accordingly, per Board Rule 19.2, the Board deemed the 2009 Ascension Health DSH Medicare/Medicaid Fraction Part C Days CIRP group complete.

The Board finds that: (1) 42 C.F.R. § 405.1837(b)(1)(i) and Board Rule 19.2 required Borgess Medical Center to be in the CIRP group referenced above as Borgess Medical Center was part of Ascension Health in 2009; and (2) as the 2009 CIRP group has since fully formed and closed, Borgess Medical Center forfeited its right to appeal the Part C Days issue for 2009. The Board's decision is consistent with the mandate in 42 C.F.R. § 405.1837(e)(1) that "[w]hen the Board has determined that a [CIRP] group appeal . . . 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."[8] As it has come to the Board's attention that the Provider is prohibited from pursuing appealing the Part C Days issue in this appeal as it was pursued in group Case No. 13-2615GC, the Board is reopening the decision to remand the Part C Days issue pursuant to 42 C.F.R. § 405.1885.

Accordingly, based on the above findings, the Board hereby **rescinds** the January 7, 2021 Remand of Part C Days Under CMS Ruling CMS-1739-R, and hereby **dismisses** the Part C Days issue from the appeal. The regulation at 42 C.F.R. § 405.1837(b)(1)(i) and Board Rule 19.2 required Borgess Medical Center to be in the Ascension Health 2009 DSH Medicare/Medicaid Fraction Part C Days CIRP Group, and 42 C.F.R. § 405.1837(e)(1) precludes Borgess Medical Center from pursuing this issue now in this individual appeal.

[7] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[8] (Emphasis added.)

Remaining Issues in Appeal Dismissed:

There are four issues remaining in this appeal:

- Issue 2 – DSH SSI Percentage (Systemic Errors)
- Issue 7 - DSH SSI Fraction/Dual Eligible Days
- Issue 8 – DSH Medicaid Fraction/Dual Eligible Days
- Issue 9 – Outlier Payments – Fixed Loss Threshold

The Board issued a Jurisdictional Decision in this appeal on March 17, 2021 in which it dismissed Issue 1 - DSH SSI Percentage (Provider Specific). The Jurisdictional Decision addressed the applicability of the mandatory CIRP regulation at 42 C.F.R 405.1837(b)(1) to this appeal, and advised that the remaining four issues in the appeal must be pursued in Common Issue Related Party ("CIRP") groups as the Provider is commonly owned by Ascension Health (as admitted by the Provider). Specifically, the Board ordered that the Provider's Representative confer with the Provider, and following that conference, either: (1) transfer the remaining three common DSH issues to CIRP groups; or (2) attest that there are no other commonly owned providers for this fiscal year, that either are, or could be pursuing the four remaining issues. The Provider was advised that its response must be received *no later than sixty (60) days from the date of the letter*, that the deadline was firm and ***specifically exempted*** from the Board Alert 19 suspension of Board set deadlines, and that failure to respond may result in the dismissal of the four issues.

Even at this late date, no response has been received by the Board regarding the four remaining issues in the appeal. As a result of the Provider's failure to timely respond to the Board's deadline as well as the Provider's failure to comply with the CIRP regulations, the Board hereby dismisses four remaining issues in this appeal pursuant to Board Rule 41.2 and 42 C.F.R. § 405.1868(b)

****

As there are no remaining issues in this appeal, the Board hereby closes it 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:

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For the Board:

3/11/2022

X Clayton J. Nix

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination***
Case No. 13-1376GC - Carolinas Healthcare System 2008 DSH SSI Fraction Denominator/Dual Eligible CIRP Group
Case No. 14-4030GC - QRS Carolinas HealthCare System 2008 Medicaid Fraction/Dual Eligible Days CIRP Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 11, 2022 request for expedited judicial review ("EJR") in the two above-referenced common issue related party ("CIRP") group appeals. The decision of the Board is set forth below.

Issue in Dispute

For the CIRP group under Case No. 13-1376GC, the group appeal request outlined three separate issue which were each assigned their own CIRP groups. The remaining issue in this group case is titled "Medicare and Medicaid Dual Eligible Days" and is framed as follows:

> Providers request a group appeal hearing . . . to challenge the DSH regulation which prohibits the inclusion of dual eligible days in the numerator of the Medicaid fraction and requires the inclusion of all Medicare Part A eligible-but-not-entitled days in the Medicare/SSI fraction. See 42 C.F.R. § 412.106(b)(2); 69 Fed. Reg. 48916, 49098-99 (Aug. 11, 2004). The Provider Group disagrees with the inclusion of Medicare Part A eligible-but-not-entitled days in the Medicare/SSI fraction and the exclusion from the numerator of the Medicaid fraction of dual eligible days including, but not limited to, the following categories of dual-eligible days:
>
> - Medicaid paid days
> - Days not paid by Medicare under Medicare Secondary Payer
> - Days after exhaustion of Medicare Part A benefits for inpatient hospital services
> - Non-Covered days

> The Provider Group contends that to the extent that these patient days are dual-eligible they should be included in the Medicaid fraction (and not the SSI fraction) because these days are attributable to patients who, for such days, were eligible for Medicaid but not entitled to inpatient hospital benefits under Medicare Part A. Although we are appealing CMS's errors in calculating the SSI fraction, and we consider the inclusion of Medicare Part A eligible-but-not-entitled days in the Medicare/SSI fraction to be an error, we expect the removal of those days from the SI fraction will result in the inclusion of the Medicaid-eligible portion of those day s in the Medicaid fraction.
>
> The Provider Group contends that the exclusion of dual eligible patient days from the Medicaid fraction and their inclusion in the SSI fraction is contrary to the plain language of the DSH statute at 42 U.S.C. § 1394ww(d)(5)(F)(vi)(II). See Metropolitan Hosp., Inc. v. U.S. Dept. of Health and Human Servs., 702 F.Supp.2d 808 (W.D. Mich. 2010) (finding that an individual is not entitled to benefits under Part A when he or she is not entitled to have Medicare Part A payment made for an inpatient hospital day).

Similarly, in the CIRP group under Case No. 14-4030GC, the group issue statement frames the "Medicaid Fraction/Dual Eligible Days" issue as follows:

> **Statement of Issue**
>
> 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 Lead MAC should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.
>
> **Statement of Legal Basis**
>
> The Provider contends that the Lead 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 Lead 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(s) contend(s) 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 Providers' contention that these days must be included in the Medicaid percentage.

While the two issue statements are essentially the same, the Board required the formation of two separate groups as there are two legal issues involved in the issue statement where, as denoted by the title of each group, one applies to the DSH SSI fraction and the other to the DSH Medicaid fraction. Specifically, the CIRP group under Case No. 13-1376GC challenges the inclusion of noncovered Medicare days in the SSI fraction (as mandated by the regulatory revisions made by the FY 2005 IPPS Final Rule); and the CIRP group under Case No. 14-4030GC alleges that, if the days at issue are excluded from the SSI fraction (*i.e.*, following a successful reversal of the regulatory revisions made by the FY 2005 IPPS Final Rule), then the subset of days that are associated with Medicaid eligible patients should be included in the numerator of the Medicaid fraction (as opposed to simply being excluded from the SSI fraction and the numerator of the Medicaid fraction as was done prior to the FY 2005 IPPS Final Rule). The Board views the EJR request as a consolidated request encompassing both CIRP groups.

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").[1] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[2]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[3] 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.[4]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[5] 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.[6] The DPP is defined as the sum of two fractions expressed as percentages.[7] 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 . . . .[8]

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.[9]

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

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

> 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.[10]

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.[11]

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.[12] 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.[13]

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."[14] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[15] 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."[16]

The Secretary stated that he believed that the *current* policy regarding dual eligible patients, *i.e.*, 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).[17] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for

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[10] (Emphasis added.)
[11] 42 C.F.R. § 412.106(b)(4).
[12] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *Id.* at 27207-27208 (emphasis added).
[17] *Id.* at 27207-08.

Medicare contractors[18] 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.[19]

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.[20] 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.[21] 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. [22] 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.[23]

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.[24] 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."[25]

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.[26]

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:

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[18] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[19] 68 Fed. Reg. at 27208.
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[25] *Id.*
[26] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> 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.[27]
>
> ****
>
> . . . [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*.[28]

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."[29] 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."[30] Prior to this revision, § 412.106(b)(2) (2004) had stated:

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[27] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[28] *Id.* at 49099 (emphasis added).
[29] *Id.*
[30] *See id.* at 49099, 49246.

> (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 . . .[31]

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 . . .[32]

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."[33]

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*"),[34] 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.[35] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures

[31] (Emphasis added.)
[32] (Emphasis added.)
[33] *Id.*
[34] 317 F. Supp. 3d 168 (D.D.C. 2018).
[35] *Id.* at 172.

and that the rule is *not* procedurally defective.[36] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[37] 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.[38] 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*"),[39] 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*,[40] 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.[41]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[42] 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."[43] 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.[44] 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 context 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[45] and that the regulation is procedurally invalid.[46]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[47] 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

[36] *Id.* at 190.
[37] *Id.* at 194.
[38] *See* 2019 WL 668282.
[39] 718 F.3d 914 (2013).
[40] 657 F.3d 1 (D.C. Cir. 2011).
[41] 718 F.3d at 920.
[42] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[43] *Id.* at 1141.
[44] *Id.*
[45] *Id. at 1162.*
[46] *Id. at 1163*
[47] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).

rulemaking requirements of the APA.[48] 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."[49] 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*")[50] 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."[51] 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."[52] 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."[53] 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).

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[54] Thus, 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.

Providers' Position

The Providers are challenging the inclusion of certain non-covered (Part A exhausted) patient days in the Medicare fraction. They argue that these days should either be in the numerator *and* denominator of the Medicare fraction, or excluded from both and instead recognized in the numerator of the Medicaid fraction. They argue that the amendments effective October 1, 2004 to 42 C.F.R. § 412.106(b)(2)(i), which mandate inclusion of the Part A exhausted benefit days be included in the Medicare fraction, are invalid. They claim that the 2004 rulemaking violates the Administrative Procedure Act ("APA") due to inadequate notice and because the final rule was

[48] *Id.* at 884.
[49] *Id.* at 884.
[50] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[51] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[52] *Id.* at 886.
[53] *Id.*
[54] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

not the product of reasoned decision-making. The Providers maintain that their position is consistent with the decision in *Empire Health Foundation v. Azar* (as referenced above).

The Providers note that there are no factual issues to be resolved and that the issue involves whether as a matter of law the regulations mandating inclusion of non-covered days in the Medicare fraction are illegal. Since the Board has jurisdiction and the issue involves a challenge to the validity of one of the Secretary's regulations, the Providers request the Board grant EJR.

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. Jurisdiction

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[55] 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.[56]

On August 21, 2008, new regulations governing the Board were effective.[57] 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*").[58] 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

[55] 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.).
[56] *Bethesda*, 108 S. Ct. at 1258-59.
[57] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[58] 201 F. Supp. 3d 131 (D.D.C. 2016).

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.[59]

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 some of the Providers involved with the instant EJR request involve cost report periods which began on or after December 31, 2008 but prior to January 1, 2016 and are governed by CMS Ruling CMS-1727-R. The Board finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. Similarly, for the Providers with cost report periods which began prior to December 31, 2008, the Board finds that it has jurisdiction over the "entitled to benefits question" under the rationale in *Bethesda* because the issue is governed by a regulation which left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers.

The Medicare Contractor did file a Response to the request for EJR on February 21, 2022. The Medicare Contractor acknowledged that the Providers' challenge to the 2004 regulations at issue is beyond the scope of the Board's authority to review. It also acknowledged the amount in controversy exceeds the $50,000 threshold for a group appeal. It did note, however, that it was unable to confirm that the appeal requests were timely received by the Board. Based on the record in each case and the jurisdictional documentation submitted, however, the Board finds that each of the Providers in both appeals timely filed their appeals and/or requests to add the relevant issue.

The Providers' jurisdictional documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[60] The appeals for each provider were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

[59] *Id.* at 142.
[60] *See* 42 C.F.R. § 405.1839.

B. Board's Analysis Regarding the Appealed Issue

The two CIRP group appeals in these EJR requests involve the 2008 cost reporting periods and involve the same 19 participants. 42 C.F.R. § 405.1867 specifies that "[i]n exercising its authority to conduct proceedings under this subpart, the Board ***must*** *comply with* all the provisions of Title XVIII of the Act and *regulations issued thereunder* . . . ."[61] Consequently the Board finds that it is bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Providers, namely: (1) invalidating the amendments FY 2005 IPPS Final Rule, as amended, so as to exclude noncovered Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issue and calendar year under appeal in each of these cases.

In making this finding, the Board notes that, as described above, the Providers maintain in their EJR request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated (either procedurally or substantively) and that, instead of reverting back to the prior policy of the Secretary under which such days were counted in neither fraction, those days should be counted in the numerator of the Medicaid fraction to the extent they involve patients who were also Medicaid eligible. In the alternative, the Providers request that these no-pay Part A days simply not be counted in either fraction, *i.e.,* that, consistent with the 9th Circuit's decision in *Empire*, the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only "covered" patient days be reinstated so that the days at issue are not counted in either fraction.

As evidenced, by the 9th Circuit's decision in *Empire*, the invalidation of the DSH no-pay Part A days policy finalized in the FY 2005 IPPS Final Rule does not *automatically* result in noncovered dual eligible days being counted in the Medicaid fraction. In this regard, the Board notes that it is clear that the *class of patients* who are dual eligibles do, in fact, have Medicare Part A (i.e., they are enrolled in Medicare Part A) and that, as a *patient class*, days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** under the Medicare Part A and were "entitled" to Part A benefits).[62] To this end, 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*")[63] and CMS Ruling 1498-R2 wherein multiple possible treatments

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[61] (Emphasis added.)

[62] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).

[63] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients

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*").[64] Thus, in the event the Supreme Court upholds the 9th Circuit's decision in *Empire*, the Providers would be arguing that the prior policy of excluding from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.

Accordingly, the Board continue to maintain that the legal argument in Case No. 13-1376GC advocating for exclusion of non-covered days from the SSI fraction is a separate and distinct issue from the legal argument in Case No. 14-4030GC advocating inclusion of the subset of no-pay part A days that involve patients who are eligible for Medicaid. As a consequence, the Board is treating the EJR request as a consolidated request involving the two CIRP groups at issue.

C. 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 Providers in these appeals are entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule), there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid and, if successful, what policy should then apply which necessarily would determine the appropriate relief, namely whether to simply exclude such non-covered Part A days from both the SSI and Medicaid fraction (as was done prior to the FY 2005 IPPS Final Rule) or to count only those non-covered Part A days involving patients who are also eligible Medicaid in the Medicaid fraction.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

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[64] *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"*).

Board Members Participating:

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FOR THE BOARD:

3/17/2022

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***EJR Determination***
Case No. 20-0164GC - Hartford Health CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP
Case No. 20-0162GC - Hartford Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' January 12, 2022[1] and February 16, 2022 requests for expedited judicial review ("EJR") in the above-referenced Hartford Health 2016 common issue related party ("CIRP") group appeals. The decision of the Board for the two Dual Eligible related appeals, both the Medicare and Medicaid fractions, is set forth below.

Issue in Dispute

In their group issue statements, the Providers frame their dual eligible days issue as follows:

> **Statement of Issues**
>
> 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 Lead MAC should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.[2]
>
> 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")

[1] 20-0162GC was filed on January 12, 2022 as part of a consolidated grouping of 80 appeals. The Board notified the parties on March 15, 2022, that this single case was being bifurcated from the consolidated grouping and, threby, excluded from the Scheduling Order issued for that consolidated grouping. To date, no party has filed any comments on this Board action.
[2] Issue statement 20-0164GC.

> calculation. Further, whether the Lead 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.[3]
>
> **Statement of Legal Basis**
>
> The Provider(s) contend(s) that the Lead 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 Lead 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(s) contend(s) 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. [4]

While the two issue statements are essentially the same, the Board required the formation of two separate groups as there are two legal issues involved in the issue statement where, as denoted by the title of each group, one applies to the DSH SSI fraction and the other to the DSH Medicaid fraction. Specifically, the CIRP group under Case No. 20-0162GC challenges the inclusion of noncovered Medicare days in the SSI fraction (as mandated by the regulatory revisions made by the FY 2005 IPPS Final Rule); and the CIRP group under Case No. 20-0164GC alleges that, if the days at issue are excluded from the SSI fraction (*i.e.*, following a successfully reversal of the

[3] Issue Statement 20-0162GC.
[4] Included as the Statement of the Legal Basis in both appeals.

regulatory revisions made by the FY 2005 IPPS Final Rule), then the subset of days that are associated with Medicaid eligible patients should be included in the numerator of the Medicaid fraction (as opposed to simply being excluded from both the SSI fraction and numerator of the Medicaid fraction as was done prior to the FY 2005 IPPS Final Rule). The Board views the EJR request as a consolidated request encompassing both CIRP groups.

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").[5] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[6]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[7] 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.[8]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[9] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[10] The DPP is defined as the sum of two fractions expressed as percentages.[11] 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

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

> such days) were *entitled to benefits under part A* of this subchapter . . . .[12]

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.[13]

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.[14]

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.[15]

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.[16] 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.[17]

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

[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(2)-(3).
[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(4).
[16] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[17] *Id.*

Medicare fraction before and after Medicare coverage is exhausted."[18] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[19] 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."[20]

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).[21] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[22] 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.[23]

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.[24] 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.[25] 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. [26] 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.[27]

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[18] *Id.*
[19] *Id.*
[20] *Id.* at 27207-27208.
[21] *Id.* at 27207-08.
[22] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[23] 68 Fed. Reg. at 27208.
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.*

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.[28] 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."[29]

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.[30]

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.[31]
>
> ****
>
> . . . [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*

[28] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[29] *Id.*
[30] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[31] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).

> *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*.[32]

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."[33] 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."[34] 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 . . .[35]

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 . . .[36]

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[32] *Id.* at 49099 (emphasis added).
[33] *Id.*
[34] *See id.* at 49099, 49246.
[35] (Emphasis added.)
[36] (Emphasis added.)

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."[37]

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*"),[38] 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.[39] 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.[40] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[41] 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.[42] 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*"),[43] 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*,[44] 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.[45]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[46] 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."[47] 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.[48] 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 context in which to view the Secretary's

[37] *Id.*
[38] 317 F. Supp. 3d 168 (D.D.C. 2018).
[39] *Id.* at 172.
[40] *Id.* at 190.
[41] *Id.* at 194.
[42] *See* 2019 WL 668282.
[43] 718 F.3d 914 (2013).
[44] 657 F.3d 1 (D.C. Cir. 2011).
[45] 718 F.3d at 920.
[46] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[47] *Id.* at 1141.
[48] *Id.*

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[49] and that the regulation is procedurally invalid.[50]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[51] 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.[52] 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."[53] 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*")[54] 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."[55] 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."[56] 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."[57] 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).

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[58] Thus, as of the date of this decision, the Secretary's position with respect

[49] *Id. at 1162.*
[50] *Id. at 1163*
[51] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[52] *Id.* at 884.
[53] *Id.* at 884.
[54] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[55] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[56] *Id.* at 886.
[57] *Id.*
[58] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

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.

Providers' Position

The Providers are challenging the inclusion of certain non-covered (Part A exhausted) patient days in the Medicare fraction. They argue that these days should either be in the numerator *and* denominator of the Medicare fraction, or excluded from both and instead recognized in the numerator of the Medicaid fraction. They argue that the amendments effective October 1, 2004 to 42 C.F.R. § 412.106(b)(2)(i), which mandate inclusion of the Part A exhausted benefit days be included in the Medicare fraction, are invalid. They claim that the 2004 rulemaking violates the Administrative Procedure Act ("APA") due to inadequate notice and because the final rule was not the product of reasoned decision-making. The Providers maintain that their position is consistent with the decision in *Empire Health Foundation v. Azar* (as referenced above).

The Providers note that there are no factual issues to be resolved and that the issue involves whether as a matter of law the regulations mandating inclusion of non-covered days in the Medicare fraction are illegal. Since the Board has jurisdiction and the issue involves a challenge to the validity of one of the Secretary's regulations, the Providers request the Board grant EJR.

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. Appeals of Cost Report Periods Beginning Prior to January 1, 2016

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in Bethesda Hospital Association v. Bowen ("Bethesda").[59] 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

[59] 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.).

of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[60]

On August 21, 2008, new regulations governing the Board were effective.[61] 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*").[62] 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.[63]

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 Providers in both cases involved with the instant EJR request involve cost report periods which began *prior to* January 1, 2016 and are governed by CMS Ruling CMS-1727-R. The Board finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in this case. In addition, the Providers' jurisdictional documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[64] The appeals for each provider were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

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[60] *Bethesda*, 108 S. Ct. at 1258-59.
[61] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[62] 201 F. Supp. 3d 131 (D.D.C. 2016).
[63] *Id.* at 142.
[64] *See* 42 C.F.R. § 405.1839.

B. Board's Analysis Regarding the Appealed Issue

The two CIRP group appeals in these EJR requests involve the 2016 cost reporting periods and involve the same 4 participants. 42 C.F.R. § 405.1867 specifies that "[i]n exercising its authority to conduct proceedings under this subpart, the Board ***must*** *comply with* all the provisions of Title XVIII of the Act and *regulations issued thereunder* . . . ."[65] Consequently the Board finds that it is bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Providers, namely: (1) invalidating the amendments FY 2005 IPPS Final Rule, as amended, so as to exclude noncovered Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issue and calendar year under appeal in each of these cases.

In making this finding, the Board notes that, as described above, the Providers maintain in their EJR request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated (either procedurally or substantively) and that, instead of reverting back to the prior policy of the Secretary under which such days were counted in neither fraction, those days should be counted in the numerator of the Medicaid fraction to the extent they involve patients who were also Medicaid eligible. In the alternative, the Providers request that these no-pay Part A days simply not be counted in either fraction, *i.e.,* that, consistent with the 9th Circuit's decision in *Empire*, the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only "covered" patient days be reinstated so that the days at issue are not counted in either fraction.

As evidenced, by the 9th Circuit's decision in *Empire*, the invalidation of the DSH no-pay Part A days policy finalized in the FY 2005 IPPS Final Rule does not *automatically* result in noncovered dual eligible days being counted in the Medicaid fraction. In this regard, the Board notes that it is clear that the *class of patients* who are dual eligibles do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, as a *patient class*, days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** under the Medicare Part A and were "entitled" to Part A benefits).[66] To this end, 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*")[67] and CMS Ruling 1498-R2 wherein multiple possible treatments

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[65] (Emphasis added.)
[66] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[67] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients

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*").[68] Thus, in the event the Supreme Court upholds the 9th Circuit's decision in *Empire*, the Providers would be arguing that the prior policy of excluding from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.

Accordingly, the Board continue to maintain that the legal argument in Case No. 20-0162GC advocating for exclusion of non-covered days from the SSI fraction is a separate and distinct issue from the legal argument in Case No. 20-0164GC advocating inclusion of the subset of no-pay part A days that involve patients who are eligible for Medicaid. As a consequence, the Board is treating the EJR request as a consolidated request involving the two CIRP groups at issue.

C. 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 Providers in these appeals are entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule), there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid and, if successful, what policy should then apply which necessarily would determine the appropriate relief, namely whether to simply exclude such non-covered Part A days from both the SSI and Medicaid fraction (as was done prior to the FY 2005 IPPS Final Rule) or to count only those non-covered Part A days involving patients who are also eligible Medicaid in the Medicaid fraction.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. The cases are now closed.

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[68] *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"*).

Board Members Participating:

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Gregory H. Ziegler, CPA
Robert A. Everts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

FOR THE BOARD:

3/17/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination***
Seattle Cancer Care Alliance (Prov. No. 50-0138)
FYEs 6/30/2011, 6/30/2012
Case Nos. 16-0161, 16-0163

Dear Mr. Jacob:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's March 4, 2022 request for expedited judicial review (EJR) for the above-referenced individual appeals for Seattle Cancer Care Alliance. The decision of the Board is set forth below.

Issue under Dispute

In these cases, the issue under dispute is:

> [W]hether the Board has the authority to decide the validity of the agency rule delaying the effective date of the OPPS payment adjustment as adopted in 75 Fed. Reg. 71800, 71885-87 (Nov. 24, 2010), 76 Fed. Reg. 74122, 74202-06 (Nov. 30, 2011), and 42 C.F.R. § 419.42(i)(1).

Statutory and Regulatory Background

Since the inception of the Outpatient Prospective Payment System ("OPPS"), Medicare has paid cancer hospitals[1] under OPPS. Cancer hospitals are exempt from payment under the Inpatient Prospective Payment System ("IPPS"). The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 ("BBA") (Pub. L. 106-113) created 42 U.S.C. § 1395l(t)(7), "Transitional Adjustment to Limit Decline in Payment" (TOPS) which serves as a permanent payment floor by limiting cancer hospitals potential losses under OPPS. Through 42 U.S.C. § 1395l(t)(7)(D)(ii), a cancer hospital receives the full amount of the difference between

[1] 42 U.S.C. § 1395ww(d)(1)(B)(v) identifies cancer hospitals. There are 11 cancer hospitals in the country, for a list of those hospitals see: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/PPS_Exc_Cancer_Hospasp.

payments for covered outpatient services under OPPS and a pre-BBA amount. This resulted in cancer hospitals receiving 83 percent of their reasonable costs.[2]

On March 30, 2010, Congress enacted the Patient Protection and Affordable Care Act (Pub. L. 111-148) ("ACA").[3] ACA § 3138 instructed the Secretary to conduct a study to determine if, under OPPS, outpatient costs incurred by cancer hospitals exceeded the costs incurred by other hospitals which furnishing services under § 1395l(t). This section of ACA was codified at 42 U.S.C. § 1395l(t)(18) and states that:

> (A) STUDY.—The Secretary[4] shall *conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1395ww(d)(1)(B)(v) of this title with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection* (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.
>
> (B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1395ww(d)(1)(B)(v) of this title exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary *shall*, subject to subparagraph (C), provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after ***January 1, 2011***.[5]

The Secretary conducted a study and it revealed that that cancer hospitals costs were higher; and as a result, the Secretary proposed to raise each cancer hospital's payment to charge ratio ("PCR") to the weighted average PCR for all other hospitals paid under OPPS in the calendar year ("CY") 2011 dataset. However, in the CY 2011 Final OPPS Rule, after reviewing commenters concerns to the proposed changes, the Secretary announced that further study of the matter was needed and stated that the adjustment to cancer hospital payments would ***not*** be finalized:

> The many public comments we received have identified a broad range of very important issues and concerns associated with the proposed cancer hospital adjustment. After consideration of these public comments, we have determined that further study and deliberation related to these issues is critical. This process,

[2] 75 Fed. Reg. 71800, 71883 (Nov. 24, 2010).
[3] *Id.* 71806.
[4] of the Department of Health and Human Services.
[5] (emphasis added).

> however, will take a longer period of time than is permitted in order for us to meet the publication deadline of this final rule with comment period. Therefore, we are not finalizing an adjustment for certain cancer hospitals identified in section 1886(d)(1)(B)(v) of the Act at this time. [6]

Subsequently, in the CY 2012 Final OPPS Rule, the Secretary announced the results of the reconsideration of commenters concerns regarding CY 2011 proposed changes to cancer hospital reimbursement.[7] Among other things, the 2012 changes for eliminated the potential increase to patient co-payments. In addition, the actual amount of the CY 2012 cancer hospital payment adjustment was determined at the cost report settlement and would be dependent on each hospital's CY 2012 payments and costs. In implementing the payment adjustment, the Secretary stated that the payment adjustments for cancer hospitals were estimated to result in an aggregate increase in OPPS payments to cancer hospitals of 34.5 percent for 2012 and a net increase in total payment, including TOPS, of 9.5 percent.[8]

With respect to the implementation of the payment adjustment for CY 2011, the Secretary stated the following in the preamble to the CY 2012 Final OPPS Rule:

> With regard to the implementation date for the cancer hospital payment adjustment, the agency did not finalize the proposed cancer hospital adjustment for CY 2011 for a variety of reasons, as explained in the CY 2011 OPPS/ASC final rule with comment period. Significantly, the majority of all commenters expressed concerns about implementation of the adjustment and, based on the broad range of important issues and concerns raised by them, we did not implement a cancer hospital adjustment for CY 2011. Moreover, the obligation to provide a cancer hospital payment

[6] 75 Fed. Reg. at 71887. *See also* 76 Fed. Reg. at 74202 (stating "The public comments associated with the cancer hospital adjustment that we proposed for CY 2011 are detailed in the CY 2011 OPPS/ASC final rule with comment period (75 FR 71886 through 71887). Many commenters urged CMS to consider TOPs when calculating the cancer hospital payment adjustment, stating that the proposed methodology results, largely, in a change in the form of outpatient payments to cancer hospitals by shifting payment from hold harmless payment under the TOPs provision to APC payments. Noting that the majority of cancer care provided in the country is provided by the noncancer hospitals that would experience a payment reduction under the CY 2011 proposal, commenters also suggested that the associated budget neutral payment reduction of 0.7 percent was not appropriate or equitable to other OPPS hospitals. Commenters also expressed concern that the proposed payment adjustment would increase beneficiary copayments. That is, they believed that the proposed cancer hospital adjustment would increase APC payments and, because beneficiary copayment is a percentage of the APC payment, Medicare beneficiaries seeking services at the 11 designated cancer hospitals would experience higher copayments due to the proposed methodology. These commenters encouraged CMS to implement the adjustment in a way that does not increase beneficiary copayments. As indicated in the CY 2011 OPPS/ASC final rule with comment period (75 FR 71887), because the many public comments we received identified a broad range of very important issues and concerns associated with the proposed cancer hospital payment adjustment, we determined that further study and deliberation was necessary and, therefore, we did not finalize the CY 2011 proposed payment adjustment for certain cancer hospitals.").
[7] 76 Fed. Reg. 74122, 74199-74206 (Nov. 30. 2011).
[8] *Id.* at 74206.

> adjustment is triggered only insofar as the Secretary determines under section 1833(t)(18)(A) of the Act that costs incurred by hospitals described in section 1886(d)(1)(B)(v) of the Act exceed those costs incurred by other hospitals furnishing services under this subsection. Several commenters raised concerns about the agency's study of costliness conducted under section 1833(t)(18)(A) of the Act; for example, a commenter suggested that the CMS analysis was inadequate to conclude that costs are higher in cancer hospitals and that an adjustment was warranted. *Given the uncertainty surrounding these issues as well as public comments arguing against implementing a cancer hospital payment adjustment for CY 2011, we decided* ***not*** *to do so for CY 2011. We note that, insofar as the cancer adjustment is* ***budget neutral****, the lack of a cancer hospital payment adjustment for CY 2011 also means that other payments were not reduced for CY 2011 to offset the increased payments from the adjustment.*[9]

Provider's Position

The Provider explains that ACA § 3138 required the Secretary perform a study of the costs incurred by the nation's 11 comprehensive cancer centers to determine if costs they incurred to provide services under OPPS exceeded the costs incurred by other hospitals for the same type of services. The statute required the Secretary to "provide for an appropriate adjustment" to the OPPS payments to the comprehensive cancer centers, if and to the extent that "the Secretary determines. . . [their] costs. . .exceed those costs incurred by other hospitals" for outpatient services paid under OPPS.[10] The Provider contends that the statute mandates in no uncertain terms that the adjustment must be "effective for services furnished on or after January 1, 2011."[11]

Further, the Provider notes that, in 2010, the Secretary performed a study, determined that the 11 comprehensive cancer centers' costs exceeded the costs incurred by other hospitals, and proposed a payment adjustment that would raise OPPS payment for cancer centers to a level equal to 91 percent of their costs. This was on par with the average OPPS payment-to-cost ratio that the Secretary identified, based on the study, for the other hospitals that were paid under OPPS.[12] However, the Secretary did not make the required payment adjustment effective January 1, 2011, as the statute mandated. Instead, the Secretary delayed implementation of the payment adjustment until January 1, 2012.[13]

The Provider contends that the Secretary's failure to make the comprehensive cancer payment adjustment effective as of January 1, 2011 is contrary to the plain language and manifest intent

[9] (Emphasis added.)
[10] 42 U.S.C. § 1395l(f)(18)(B).
[11] *Id.*
[12] *See* 75 Fed. Reg. at 71,886 and 76 Fed. Reg. at 74202-06.
[13] *See* 76 Fed. Reg. at 74583.

of the statute, 42 U.S.C. § 1395l(t)(18). The Provider maintains that the statute mandates an effective date of January 1, 2011, not January 1, 2012, and the Secretary is not free to comply selectively with some statutory requires and ignore others. The Provider asserts that the Secretary's failure to make the payment adjustment effective as of January 1, 2011 is arbitrary, capricious, not based upon substantial evidence and otherwise contrary to law. Because the Board has jurisdiction over the appeals, but lacks the authority to grant the relief sought, the Provider believes the Board should grant EJR.

Decision of the Board

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

A. Jurisdiction

The participants that comprise the appeals within this EJR request have filed appeals involving fiscal years 2011 and 2012.

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 issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[14] 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.[15]

On August 21, 2008, new regulations governing the Board were effective.[16] 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*").[17] In *Banner*, the provider filed its cost report in accordance with the applicable

[14] 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.).
[15] *Bethesda*, 108 S. Ct. at 1258-59.
[16] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[17] 201 F. Supp. 3d 131 (D.D.C. 2016).

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.[18]

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

B. Jurisdiction and EJR

The Board has determined that the Provider involved with the instant EJR request is governed by CMS Ruling CMS-1727-R for both of the years at issue because the Provider is challenging the validity the Secretary's failure to implement the Medicare payment adjustment in 42 U.S.C. § 1395l(t)(18)(B) as addressed in the rulemakings published in the Federal Register at 75 Fed. Reg. 71800, 71885-87 (Nov. 24, 2010) and 76 Fed. Reg. 74122, 74202-06 (Nov. 30, 2011). In addition, the Board finds that this issue does not fall with a matter excluded from Board reviw by statute or regulation.[19] Finally, the appeals were timely filed and the participant's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal.[20] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Provider. 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 whether the Secretary's failure to implement the Medicare payment adjustment in 42 U.S.C. § 1395l(t)(18)(B) as addressed in the rulemakings published in the Federal Register at 75 Fed. Reg. 71800, 71885-87 (Nov. 24, 2010), 76 Fed. Reg. 74122, 74202-06 (Nov. 30, 2011) is valid. Consequently, the Board finds that EJR is appropriate.

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[18] *Id.* at 142.
[19] *See* 42 C.F.R. § 405.1840(b) (addressing certain matters precluded from administrative review by statute or regulation). For example, 42 U.S.C. § 1395l(t)(12) lists certain OPPS matters of OPPS that are excluded from administrative and judicial review; however, the issue in these cases does not fall within those excluded matters.
[20] *See* 42 C.F.R. § 405.1835(a)(2).

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 participant in this these appeals are entitled to a hearing before the Board;

2) Based upon the participant's assertions regarding validity of the implementation of the Medicare payment adjustment in 42 U.S.C. § 1395l(t)(18)(B) as addressed in the Federal Register at 75 Fed. Reg. 71800, 71885-87 (Nov. 24, 2010) and 76 Fed. Reg. 74122, 74202-06 (Nov. 30, 2011), 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 implementation of the Medicare payment adjustment in 42 U.S.C. § 1395l(t)(18)(B) as addressed in the rulemakings published in the Federal Register at 75 Fed. Reg. 71800, 71885-87 (Nov. 24, 2010) and 76 Fed. Reg. 74122, 74202-06 (Nov. 30, 2011) is valid.

Accordingly, the Board finds that the question of the validity of the Secretary's implementation of the Medicare payment adjustment in 42 U.S.C. § 1395l(t)(18)(B) as addressed in the rulemakings published in the Federal Register at 75 Fed. Reg. 71800, 71885-87 (Nov. 24, 2010) and 76 Fed. Reg. 74122, 74202-06 (Nov. 30, 2011) 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 years. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

Board Members Participating:
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Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
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Ratina Kelly, CPA

FOR THE BOARD:

3/21/2022

X Clayton J. Nix

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

cc: John Bloom, Noridian Healthcare Solutions
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RE: ***Jurisdictional Determination***
Memorial Regional Hospital (Prov. No. 10-0038)
FYE 4/30/2011
Case No. 14-4135

Dear Mr. Hettich and Mr. Pike,

This case involves the Provider's appeal of its Medicare reimbursement for the fiscal year ending ("FYE") April 30, 2011. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation is response to the Medicare Contractor's Jurisdictional Challenge, and the June 8, 2018 decision of the U.S. Court of Appeals, District of Columbia Circuit ("D.C. Circuit") in *Mercy Hosp., Inc. v. Azar* ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the related issues within the instant appeal.

Pertinent Facts:

On September 10, 2014, the Provider filed an individual appeal request containing the following three issues relating to the inpatient prospective payment system ("PPS") for inpatient rehabilitation facilities ("IRFs"). Specifically, these three IRF-PPS issues relate to an adjustment within that payment system for low income payments ("LIP"):

> (1) Whether the MAC used the correct Supplemental Security Income ("SSI") percentage in the LIP calculation;
>
> (2) Whether the Medicaid dual eligible days should be included in the Medicaid fraction or Medicare fraction of the LIP calculation; and
>
> (3) Whether the Medicaid Part C days should be included in the Medicaid fraction or Medicare fraction of the LIP calculation.

[1] 891 F. 3d 1062 (June 8, 2018).

On September 1, 2015, the Medicare Contractor filed a jurisdictional challenge regarding all three issues in the appeal. However, the Provider did ***not*** file *any* response to the jurisdictional challenge. In this regard, the Board notes that Board Rule 44.4.3 states: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, the Board notes that, while the Provider filed its final position paper on December 30, 2021, it does not address jurisdiction much less 42 U.S.C. § 1395ww(j)(8)(B) or the D.C. Circuit's decision in *Mercy*.

Medicare Contractor's Position

The Medicare Contractor contends that the IRF-PPS LIP adjustment is a component of the IRF prospective payment rate established under 42 U.S.C. § 1395ww(j)(3)(A)(v). In accordance with § 1395ww(j)(8)(B), there is no administrative or judicial review of the IRF prospective payment rates under paragraph (3). Because the IRF LIP payment has been established under paragraph (3), the Medicare Contractor contends that the Board does not have subject matter jurisdiction over the IRF LIP payment or any of its components.

42 U.S.C. § 1395ww(j)(8)(B) specifically prohibits and precludes administrative and judicial review of prospective payment rates established under § 1395ww(j)(3). One of these adjustment to the rate is the LIP adjustment.

The Medicare Contractor cites to the Centers for Medicare and Medicaid ("CMS") Administrator's decision in *Mercy Hosp. v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. No. 2015-D7 (Apr. 3, 2015), *rev'd*, CMS Administrator Dec. (Apr. 3, 2015).

Board Decision:

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates under the IRF-PPS. Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy* answers this question and clarifies what is shielded from review in its analysis of this issue.

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the District Court's decision, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[2] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting thestandardized reimbursement rate and then calculating a hospital's final payment.[3] In particular, the D.C. Circuit stated: "[b]ecause reviewing a formula used by the prospective payment rate would effectively review the rate itself, we cannot review the former if we cannot review the latter."[4]

In the instant appeal, the Provider seeks Board review of several of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI percentage, dual eligible days, and Part C days where the Provider challenges the adopted formula or process used[5] and, as such, these issues involve precisely the situations addressed in *Mercy*. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board finds that, consistent with the D.C. Circuit's decision in *Mercy*,[6] it lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the only three (3) remaining issues in the instant appeal that challenges this

[2] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).
[3] *Mercy*, 891 F.3d at 1068.
[4] *Id.* at 1067-68.
[5] *See* Provider's Final Position Paper at 8-15(stating, with respect to Part C days and no-pay dual eligible days, the Provider claims that CMS' position on how to count such days ***in LIP*** *for IRFs* is inconsistent with how the Medicare statute requires them to be counted in the ***DSH*** payment adjustment *for IPPS*; and with respect to the SSI fraction, the Provider claims it is "understated due to ***systemic*** errors in the data matching process" as set forth in the FY 2011 IPPS final rule published on August 16, 2010 (emphasis added)).
[6] *See also DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503 (D.C. Cir. 2009).

adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent because the Provider could bring suit in the D.C. Circuit.[7]

As there are no issues remaining in the appeal, the Board hereby closes Case No. 14-4135. Review of this decision is available under 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:

3/25/2022

X Clayton J. Nix

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

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

[7] 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'rDec. (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). Notwithstanding, 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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Nan Chi
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Bill Tisdale
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RE: ***Jurisdictional Determination***
Houston Methodist Hospital (45-0358)
FYE 12/31/2012
Case No. 16-0197

Dear Ms. Chi and Mr. Tisdale:

The above-captioned individual case involves the Provider's appeal of its Medicare reimbursement for the fiscal year ending ("FYE") in 2012. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation pursuant to a jurisdictional challenge filed by the MAC. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") related issues and dismisses the instant appeal.

Pertinent Facts

On November 6, 2015, the Provider filed an appeal with the Board seeking to have patient days associated with a number of different issues including: DSH Issues, Medicaid Eligible Days, and the Low Income Proxy ("LIP") issue, pertaining to fiscal year 2012.[1] *After transfers and withdrawals*, the Medicare Contractor's ("MAC") determination of the Provider's low income percentage adjustments under the prospective payment system for inpatient rehabilitation services (hereinafter known as "IRF LIP"), are the *final remaining* issues, specifically:

- Issue 9 – LIP Eligible Days;
- Issue 10 – LIP Percentage.

Issue 9 was described as challenging whether the LIP amount was calculated correctly.[2] Issue 10 challenges whether the MAC used the correct Supplemental Security Income ("SSI") percentage in the Provider's IRF LIP adjustment.[3]

[1] *See Request for Hearing*, at Tab 3, Issue Statement (Nov. 6, 2015).
[2] *Id.*
[3] *Request to Add Issue*, at Tab 1, Issue Statement (Nov. 9, 2015).

The MAC filed a jurisdictional challenge on February 24, 2016, challenging jurisdiction over four issues, including the above-mentioned LIP issues.[4] The Provider filed a jurisdictional response on March 22, 2016.[5]

The MAC filed a challenge over the following issues:

- Issue 1 – DSH SSI-Provider Specific
- Issue 2 – DSH SSI-Systemic
- Issue 9 – LIP Eligible Days
- Issue 10 – LIP %[6]

As issues 1 and 2 have been withdrawn and transferred, respectively, they are no longer pending in this appeal. Accordingly, the Board's jurisdictional determination only addresses Issues 9 and 10.

MAC's Jurisdictional Challenge

The MAC argues that in this appeal, the Provider challenges the accuracy of the IRF LIP adjustment. The IRF LIP adjustment is a facility-level adjustment for low income patients that takes into account both the percentage of Medicare patients who are receiving Supplemental Security Income and the percentage of Medicaid patients who are not entitled to Medicare. The purpose of the LIP adjustment is to pay IRFs more accurately for the incremental increase in Medicare costs associated with the facility's percentage of low-income patients. Section 1886(j)(8)(B) of the Medicare Act specifically prohibits and precludes administrative and judicial review of prospective payment rates established under Section 1886(J)(3) of the Medicare Act.[7]

The MAC adds, that in responding to comments made in response to the Secretary's final rule in the Federal Register regarding IRF LIP adjustments, the Secretary specifically noted that the LIP adjustment was an adjustment under Section 1886(j)(3)(A)(v). Because the LIP adjustment is a component of the IRF prospective payment rate established under Section 1886(j)(3), administrative and judicial review of the LIP adjustment are statutorily precluded by Section 1886(j)(8). 42 C.F.R. § 405.1867 mandates that the Board must comply with all of the provisions of the Medicare Act and the regulations issued thereunder. Accordingly, Section 1886(j)(8)(B) of the Medicare Act precludes administrative review of the IRF-LIP adjustment, and thereby divests the Board of jurisdiction to hear issues 9 and 10 of the Provider's appeal.[8]

Based on the above, the MAC requests the Board dismiss the two remaining issues.

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[4] MAC's Jurisdictional Challenge, at 1 (Feb. 24, 2016).
[5] Provider's Jurisdictional Response (Mar. 22, 2016).
[6] MAC's Jurisdictional Challenge, at 1.
[7] *Id*. at 2.
[8] *Id*.

Provider's Response to MAC's Jurisdictional Challenge

The Provider filed a response on March 22, 2016, asserting that the Board did in fact have jurisdiction over the issues.

The Provider argues that the LIP adjustment is not precluded from administrative review. In the August 7, 2001 Federal Register beginning on page 41359, CMS initiated an adjustment for facilities serving low-income patients. This adjustment is known as the LIP adjustment. The measure used to compute an IRF percentage of low-income patients is the same measure used to measure low-income patients in acute care hospitals (i.e. DSH). All IRFs are eligible to receive a LIP adjustment. There is not a required threshold for a minimum number of beds or a minimum amount of DSH in order to receive the adjustment. The Provider contends the same definition used in the DSH Statute be applied in the LIP adjustment for IRFs pursuant to 42 C.F.R. 412.624(e)(2) and that the Board find it has jurisdiction.[9]

The MAC has argued that Section 1886(j)(8)(B) of the Medicare Act specifically prohibits and precludes administrative and judicial review of prospective payment rates established under Section 1886(j)(3) of the Medicare Act. However, consistent with Board's decision in *Mercy Hospital* v. *First* Coast service *Opti*ons, *Inc.*, PRRB Dec. No. 2015-D07 (Apr. 3, 2015), Provider argues the "prospective payment rates under 1886(j)(8)(B) is limited to the general federal "rates" before they are "adjusted" by various items, including but not limited to, LIP adjustment. Further, Section 1886(j)(8) specified the establishment of cash mix groups, general prospective payment rates under paragraph (3), outlier and area wage adjustments as non-reviewable. LIP adjustments are not one of the specific, non-reviewable establishments.[10]

The Provider further argues that the LIP adjustment is a hospital-specific adjustment. The Provider is entitled to appeal an item that it is dissatisfied with. The same considerations in 42 U.S.C. § 1395ww(j) also apply to challenges to the "estimates" used by the Secretary in computing Factors 1-3 of the Disproportionate Share Adjustment. While the IRF LIP adjustment contains a prospectively determined adjustment factor (percentage or formula containing a predetermined exponent), the LIP adjustment formula also contain hospital-specific components.[11]

The hospital-specific components are prospectively based on prior year cost report amounts for interim payment purposes, however, they are retrospectively adjusted upon final settlement of the cost report.

These hospital-specific components, i.e. SSI percentage and Medicaid percentage, are all defined elsewhere within the Act in relation to Inpatient Prospective Payment, as CMS has borrowed from existing payment methodologies in developing the IRF-PPS SSA 1886(j)(3)(v) adjustment

[9] Provider's Jurisdictional Response, at 2.
[10] *Id*.
[11] *Id*. at 3.

factors for variations in cost. These hospital-specific factors, with established definitions and administrative and judicial review rights in other areas of the Act and the regulations are not prospectively established rates. The preclusion of review in this case, if applicable at all, would apply to the formulas used in the IRF-PPS payments and adjustments and uniform Federal rates, not individual hospital-specific rates which are set on an interim basis and then settled retrospectively upon settlement.[12]

The Provider contends that the hospital-specific components, i.e. SSI percentage and Medicaid percentage, should all be subject to administrative and judicial review to ensure accuracy in final settlement. To "clarify" the existing regulation as proposed would prevent the Provider of its right to appeal and correct an improper Medicaid eligible day count. These items have been appealed and resolved on a routine basis for decades across PPS payment systems, these are not prospectively set numbers or estimates by CMS or the Secretary, they are hospital-specific items with which a Provider can be dissatisfied upon final settlement and bring a jurisdictionally proper appeal. Provider contends the above-mentioned hospital specific components in SSA 1886(j)(3)(v) of the IRF-PPS payment are not precluded from administrative or judicial review.[13]

Furthermore, the Provider contends this regulation may be challenged notwithstanding the preclusion of administrative or judicial review contained in 42 U.S.C. § 1395wwU). The statute does not authorize the Secretary to make adjustments for any reason. Rather, the statute generally specifies the criteria upon which the Secretary must make such adjustments. Accordingly, the use of improper criteria upon which to base such adjustments would not be shielded from judicial review, because such action on the part of the agency would be ultra vires, or outside of the scope of the Secretary's authority.[14]

Therefore, the Provider argues that the Board has jurisdiction over the LIP issues.

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under

[12] *Id*.
[13] *Id*.
[14] *Id*.

protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the decision of the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[15]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[16] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[17] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[18]

In the instant appeal, the Provider seeks Board review of a number of the hospital-specific components utilized by the Medicare Contractor to determine the Providers' LIP adjustments. Because, pursuant to 42 U.S.C. § 1395ww(j)(8)(B), Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the hospital-specific LIP adjustment, the Board finds that, consistent with the D.C. Circuit's decision in *Mercy*,[19] it lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment issues under Issues 9 and 10 and dismisses these issues in the instant appeal that challenge this adjustment. In making this finding, the Board relied on the *Mercy* decision (which overturned the Board decision cited by the Provider, PRRB Dec. No. 2015-D07) and notes that the D.C. Circuit's decision in *Mercy* is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(j)(8)(B) because the Provider could bring suit in the D.C. Circuit.[20] In this regard, the Board notes that the D.C. Circuit stated:

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[15] *Id*.
[16] *Id.* at 1064.
[17] *Mercy Hosp., Inc. v. Burwell,* 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[18] *Mercy*, 891 F.3d at 1068.
[19] *See also DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503 (D.C. Cir. 2009).
[20] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the

"[b]ecause reviewing a formula used by the prospective payment rate would effectively review the rate itself, we cannot review the former if we cannot review the latter."[21] Accordingly, the Board hereby dismisses Issues 9 and 10, closes the appeal, and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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For the Board:

3/25/2022

X Clayton J. Nix

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Chair
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

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). Notwithstanding, 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).

[21] *Id.* at 1067-68.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Borgess Medical Center (Prov. No. 23-0117)
FYE June 30, 2008
Case No. 13-1947

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the record in the above-captioned appeal following the Board's November 17, 2021 Jurisdictional Determination and CIRP RFI and, for the reasons outlined below, hereby ***dismisses*** the appeal in its entirety and closes the case.

Procedural Background:

On May 8, 2013, the Board received Provider's Individual Appeal Request appealing their November 9, 2012 Notice of Program Reimbursement ("NPR") for fiscal year ending June 30, 2008. The initial appeal contained the seven (7) following issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment –Medicare Managed Care Part C Days
5. DSH Medicaid Eligible Labor Room Days
6. DSH Dual Eligible Days Exhausted Part A days
7. Outlier Payments – Fixed Loss Threshold

On December 26, 2013, the Provider filed the first page of its Preliminary Position Paper ("PPP") with the Board after providing a full copy to the Medicare Contractor. Similarly, on May 1, 2014, the Medicare Contractor filed the first page of its PPP with the Board after providing a full copy to the Provider.

Over 6 years later, on September 17, 2020, the Provider filed its Final Position Paper ("FPP"). With respect to Issue 3, the Medicaid Eligible Days Issue, the Provider stated in its FPP that "[b]ased on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2008 cost report does not reflect an

accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions. *See* Exhibit 1." There is no statement of the total days at issue. Further, while there is a citation to Exhibit 1, the Exhibit 1 tab associated with the Provider's FPP includes a cover sheet stating that Exhibit 1 is the "Eligibility Listing" but that it was "not included" with the FPP because it is "being sent under separate cover." To date, no such eligibility listing has been filed with the Board. In this regard, the Board notes that Board Rule 25.2.1 states that "[w]ith the position papers, the parties must exchange all available documentation as exhibits to fully support your position." With regard to unavailable or omitted documents, Board Rule 25.2.2 explains that: "If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party." The Provider's FPP did not comply with Board Rule 25.2.2 to explain why the "Eligibility Listing" (or any other relevant supporting evidence) was not included with its FPP.

On October 19, 2020, the Medicare Contractor filed its FPP and, with respect to the Medicaid Eligible Days issue, stated that the Medicare Contactor has not received any documentation on the additional Medicaid Eligible Days being claimed:

> The Provider is not challenging the MAC's computations, but merely requesting the inclusion of additional days in the computations. However, *as of this writing*, *the Provider has* ***not*** *produced adequate evidentiary documentation to support the additional days*. The regulations establish specific guidelines for the maintenance of data and submission of cost reports. These requirements are explained at 42 C.F.R. § 413.20(d) as follows: "… (1) The provider must furnish such information to the intermediary as may be necessary to—(i) Assure proper payment by the program …; (ii) Receive program payments; and …(iii) Satisfy program overpayment determinations. (2) The provider must permit the intermediary to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due." The importance of submitting adequate data to support allowable costs is restated at 42 C.F.R. § 413.24(c): "Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization…. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis."
>
> The regulation at 42 C.F.R. § 412.106(b)(4)(iii) states:
>
> > The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid

> patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.
>
> The Provider has not complied with this basic regulation and the regulations at 42 C.F.R. § 413.20 and 413.24. . . .
>
> The Provider has had ample opportunity to submit documentation of Medicaid eligible days that were not claimed on their cost report and/or submitted at the time of the MAC's review/audit. As of this writing, the Provider has not submitted documentation of the possible additional Medicaid eligible days and/or identified specifics as to any impediments preventing such submissions.

In support of its position, the Medicare Contractor included as Exhibit C-2 to its FPP copies of emails to the Provider's Representative dated November 21, 2018 and March 5, 2019 requesting the list of additional Medicaid days being claimed as well as supporting documentation of Medicaid eligibility. Significantly, these requests were made *prior to* the Provider's representative filing the Provider's FPP

On November 17, 2021, the Board dismissed the DSH/SSI Percentage (Provider Specific) issue because it was insufficiently briefed and duplicative of the Systemic Errors issue. The Board also dismissed the Part C Days issue because the Provider is commonly owned by Ascension Health, and this provider should have been included in the 2008 CIRP group for Ascension Health for the same issue (Case No. 13-1517GC),[1] which was deemed fully formed and closed. The Board also required that, ***within sixty days of that decision (i.e., by Monday, January 17, 2022),*** the Provider transfer the remaining common issue DSH issues to CIRP groups or, in the alternative, attest that there are no other related providers for the fiscal year. The Board exempted this deadline from Alert 19, specifically noting that "failure to respond by the filing deadline may result in dismissal of the remaining issues."

On February 25, 2022 (39 days after the filing deadline), the Provider *belatedly* filed a Response. It noted that the following four issues remained:

1. DSH Payment – Medicaid Eligible Days
2. DSH Medicaid Eligible Labor Room Days
3. DSH Dual Eligible Days Exhausted Part A days
4. Outlier Payments – Fixed Loss Threshold

As this list did not include the DSH/SSI Percentage – Systemic Errors issue and this issue was not discussed in the Provider's response to the Board's RFI, it must be assumed that the Provider

[1] 42 C.F.R § 405.1837(b)(1).

abandoned the DSH/SSI Percentage - Systemic Errors issue (particularly in light of the fact that this is a common issue subject to the mandatory CIRP group rules). The Provider then elected to withdraw both the Labor Room Days issue and the Outlier Payments issue. As such, the remaining issues are the Medicaid Eligible Days and DSH Dual Eligible Days Exhausted Part A Days issues. However, the Provider appears to abandon the Medicaid Eligible Days issue as a separate issue and instead subsume it into the DSH Dual Eligible Exhausted Part A Days Issue:

> The Provider intends to pursue the Medicaid Eligible day issue, ***based on the 9th circuit court decision in Empire court case*** *which invalidated the underlying dual eligible day regulation*. The Provider believes that *the Dual Eligible Days should be treated as Medicaid Eligible Days*. Additionally, once the United States Supreme court rules on the Empire case, the dual eligible days in the instant case will be resolvable along with the Medicaid Eligible Days.
>
> As the Dual Eligible Days issue and the Medicaid eligible day issue will either proceed to a live hearing or be resolved based on the specific days in question, *this Provider should* ***not be transferred*** *to a group appeal*.[2]

Significantly, the Provider failed to any explanation as to why "the Provider should not be transferred to a group appeal" for either the Medicaid eligible days issue or the dual eligible days issue and did not certify that there were no other (and would not be any) Ascension Health providers with the same issues for this year.

Board Rule 41.2 (Nov. 1, 2021) permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- **upon failure of the provider or group to comply with Board procedures or filing deadlines (see 42 C.F.R. § 405.1868),**
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

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

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the

[2] (Emphasis added.)

> provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.

Board Decision:

The Board finds that the Provider has failed to comply with the Board's procedures, specifically the filing deadlines set in this case. Furthermore, the belated Response to the Board's CIRP RFI was deficient in numerous respects, since it failed to give any reason for the late filing, did not give a sufficient explanation as to why the 2 remaining issues should not be transferred to CIRP groups, nor did it actually attest that there are no other related providers for the fiscal year with either of the 2 remaining issues. In this regard, the Board notes that the Provider's Representative does not dispute that the Provider is part of Ascension Health and, thereby, subject to the Mandatory CIRP rules; nor is there any indication that the Representative discussed the Board's RFI with the Provider's parent corporation, Ascension Health, to determine if there were other CIRP groups to which the Provider should be transferred. Finally, it is clear that the Provider abandoned the DSH/SSI Percentage (Systemic Errors) issue since its belated response failed to list the issue or otherwise address that issue in compliance with the Board's RFI.[3]

Moreover, a wholly separate and independent basis for dismissal of the dual eligible days issue is the Provider's failure to comply with the CIRP group regulations as that was the reason underlying the RFI with which the Provider failed to comply, namely that the *Empire* dual eligible day issue is one that is common to Ascension Health and must be brought as part of a CIRP group per 42 C.F.R. § 405.1837(b)(1)).

Similarly, an independent basis for dismissing the Medicaid eligible days issue is the fact that the Provider has failed to adequately brief the issue in its FPP. Position papers are expected to present fully developed positions of the parties and include all available documentation necessary to provide a thorough understanding of the parties' positions.[4] Here, the Provider failed to: (a) identify what additional Medicaid eligible days were at issue (including ***simply*** *how*

[3] Even if the Provider had not abandoned the DSH/SSI Percentage (Systemic Errors) issue, it would be dismissed for the same reasons as the Board is dismissing the dual eligible days issue.
[4] *See* Board Rule 23.3 at Commentary, 25 at Commentary, 25.3, 27.2 (applying the PPP content requirements to FPPs).

many days are at issue); (b) describe what type(s) of days were at issue (*e.g.*, a particular class of days relating to a particular state Medicaid benefit or program); (c) describe why these types of days were at issue; and (d) include any supporting documentation such as eligibility verification. Prior to the Provider's filing its FPP, the Medicare Contractor had requested the Provider to provide this information and the Provider has not provide and, in particular, did not include it in its FPP notwithstanding its obligation to do so under Board Rules governing position papers. It is only with the information that the Board would be able determine whether the Medicaid eligible days issue is subject to the mandatory CIRP rules.[5]

Finally, as discussed above in the procedural background section, the Provider's belated response to the Board's RFI not only failed to address the Board's RFI but appears to abandon it as a separate and distinct issue and subsume it into the dual eligible days issue.[6] Indeed, without information in the record to identify the Medicaid eligible days at issue (*e.g.*, how many, what type of day, and supporting documentation) notwithstanding the fact such information was required to be provided as part of the Provider's FPP, the Board necessarily must find that it has been subsumed into the dual eligible days issue.

Accordingly, based on the untimely and deficient response and the failure to comply with the CIRP group regulations, the Board hereby dismisses the case *in its entirety* and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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For the Board:

3/31/2022

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS Government Health Administrators (J-8)
Wilson Leong, FSS

[5] It is unknown what additional days are at issue but, if the Medicaid eligible days at issue are a particular class of days (*e.g.*, non-covered dual eligible days that the provider wants counted in the Medicaid fraction as opposed to the SSI fraction or general assistance days or a state-identified Code 2 day) that would be something potentially covered by the mandatory CIRP group rules. In this regard, the Board has had CIRP groups formed around Medicaid eligible days issues such as DSH Code 2 and 3 Medicaid Eligible Days CIRP groups.

[6] The Provider's motion for postponement filed shortly thereafter on June 14, 2021 similarly does not identify Medicaid eligible days as a separate issue pending in the case but rather only identifies the Part C days issue (that the Board later dismissed) and the no-pay dual eligible days issue.