



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Daniel Hettich  
King & Spalding, LLP  
1700 Pennsylvania Avenue, Suite 200  
Washington, DC 20006-2706

**RE: *Jurisdictional Decision***  
Seton Medical Center Harker Heights (67-0080)  
PRRB Case 15-1303

Dear Mr. Hettich,

The Provider Reimbursement Review Board (“Board”) has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

**Pertinent Facts:**

The Provider in this appeal is represented before the Board by King & Spalding LLP.

The Provider filed their appeal request on January 30, 2015, challenging the Final Rule in the Federal Register issued on August 22, 2014.<sup>1</sup> The Provider’s appeal focuses on whether its DSH payment contained a calculation error related to the third factor (“Factor 3”) used to determine the payment for its proportion of uncompensated care. Specifically, the Provider has framed two issues as follows:

*Issue 1:* Whether CMS’s failure to use a full 12-month cost reporting period to determine the number of the Provider’s Medicaid eligible days in calculating factor 3 of the Provider’s uncompensated care (“UCC”) payment was lawful?

*Issue 2:* Whether CMS erred and acted beyond its authority, i.e., ultra vires, by failing to effectuate the D.C. circuit’s *Allina* decision when it calculated factor 3 in the Provider’s UCC payment.<sup>2</sup>

For Issue 1, the Provider notes that it is a new hospital and, as such, CMS used its Medicaid days from a ten month cost reporting period (“stub-period”) to calculate its UCC adjustment amount. It claims that CMS is statutorily required to calculate the UCC payment for each hospital “for a period selected by the Secretary,” and that comparing the days in a stub-period for Provider to a full twelve-month period for other providers employs different “periods” in violation of that statutory requirement.<sup>3</sup> The Provider also argues that the use of a stub-period violates the statutory requirement that any “estimate” used by the Secretary be “based on appropriate data.”<sup>4</sup> They claim that this practice arbitrarily penalizes certain

<sup>1</sup> Individual Appeal Request, Tab 3, 1 (Jan. 30, 2015); 79 Fed. Reg. 49853 (Aug. 22, 2014).

<sup>2</sup> Individual Appeal Request, Tab 3 at 1-2.

<sup>3</sup> *Id.* at 1.

<sup>4</sup> *Id.* at 1-2.

providers with “stub-periods.”<sup>5</sup> Finally, the Provider argues that it is not being provided the same protection afforded to Indian Health Service (“IHS”) hospitals. They note that, originally, because cost reports for IHS hospitals are not uploaded to HCRIS, the UCC payments calculated by CMS understated the amount of uncompensated care that IHS hospitals provide. CMS later revised its policy to consider supplemental cost report data in determining Factor 3 to allow the Medicaid days for IHS hospitals to be included.<sup>6</sup>

For Issue 2, the Provider discusses *Allina Health Servs. V. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) (“*Allina*”) with regard to the calculation of Factor 3 of the UCC payment, reiterating the argument that SSI days should exclude Medicare Advantage (“MA”) days, and MA dual eligible days should be included as Medicaid days in the FY 2015 Factor 3 calculation. They point out CMS’ position that it does not believe *Allina* has any bearing on the estimate of Factor 3 for FY 2015 since it had readopted the policy of counting MA says in the SSI ration for FY 2014 and beyond. The Provider argues that this policy still relies on SSI and Medicaid data from a period predating this re-adopted policy, and that CMS was obligated to correct those numbers to confirm with the Court’s ruling in *Allina*. The Provider contends that this approach results in CMS acting beyond its authority by continuing to treat Part C days as “days entitled to benefits under Part A” for periods pre-dating their re-adopted policy.<sup>7</sup>

The Medicare Contractor (“MAC”) filed a Jurisdictional Challenge in this case on June 8, 2018, arguing that both issues are precluded from administrative and judicial review pursuant to 42 U.S.C. § 1395ww(r)(3).<sup>8</sup> The Provider has not filed a response to the challenge.

#### **Board’s Decision:**

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

- (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).<sup>9</sup>
- (B) Any period selected by the Secretary for such purposes.

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<sup>5</sup> *Id.* at 2.

<sup>6</sup> *Id.* See also 78 Fed. Reg. 61191, 61195 (Oct. 3, 2013).

<sup>7</sup> Individual Appeal Request, Tab 3 at 2-3. See also 79 Fed. Reg. 49853.

<sup>8</sup> Medicare Administrative Contractor’s Motion to Dismiss Issue for Lack of Subject Matter Jurisdiction, 3 (June 8, 2018) (hereinafter “MAC’s Jurisdictional Challenge”).

<sup>9</sup> Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

Further, the D.C. Circuit Court<sup>10</sup> upheld the D.C. District Court's decision<sup>11</sup> that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."<sup>12</sup> The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.<sup>13</sup>

The Board finds that the same findings are applicable to the Provider's challenge to their 2015 Uncompensated Care payments. As in *Tampa General*, the Provider here is challenging the calculation of the amount they received for uncompensated care for FY 2015. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Provider is seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Provider is challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well. Furthermore, in challenging the Medicare Contractor's use of a stub-period cost report covering one time period, rather than a twelve-month cost report covering a different period, the Provider is challenging the "period selected by the Secretary" used in creating those estimates, which is also barred from review.

It should be noted that CMS did, in fact, state that it would "use the 2012 cost report, *unless that cost report is unavailable or reflects less than a full 12-month year*. In the event the 2012 cost report is for less than 12 months, [CMS] would use the cost report from 2012 or 2011 that is closest to being a full 12-month cost report. In the case where a less than 12-month cost report was used to calculate a hospital's Factor 3, this would indicate that both the 2012 and 2011 cost reports were less than 12 months. In such a case [CMS] would use the longer of the two cost reports to calculate a hospital's Factor 3."<sup>14</sup> In this case, the Provider's Individual Appeal Request does not allege that there was, in fact, a longer cost report available to use. The Provider seems to simply be challenging the fact that they were forced to use a stub-period cost report, which is the time period selected by the Secretary for this scenario, which is barred from review.

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<sup>10</sup> *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*<sup>10</sup>("Tampa General"), 830 F.3d 515 (D.C. Cir. 2016).

<sup>11</sup> 89 F. Supp. 3d 121 (D.D.C. 2015).

<sup>12</sup> 830 F.3d 515, 517.

<sup>13</sup> *Id.* at 519.

<sup>14</sup> 79 Fed. Reg. at 50019 (emphasis added).

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in this group appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes the referenced group appeal and removes it from its docket.

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

Board Members Participating:

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

For the Board:

4/1/2019

**X** Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., Federal Specialized Services  
Bill Tisdale, Novitas Solutions, Inc. (J-H)





DEPARTMENT OF HEALTH & HUMAN SERVICES

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Daniel Hettich  
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Washington, DC 20006-2706

**RE: *Jurisdictional Decision***

McLeod Loris/Seacoast Hospital (42-0105)  
PRRB Case No. 15-1313  
FYE 09/30/2015

Dear Mr. Hettich,

The Provider Reimbursement Review Board (“Board”) has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

**Pertinent Facts:**

The Provider filed their appeal request on February 2, 2015, challenging the Final Rule in the Federal Register issued on August 22, 2014.<sup>1</sup> The Provider’s appeal focuses on whether its DSH payment contained a calculation error related to the third factor (“Factor 3”) used to determine the payment for its proportion of uncompensated care. Specifically, the Provider has framed two issues as follows:

Issue 1: Whether CMS’s failure to use a full 12-month cost reporting period to determine the number of the Provider’s Medicaid eligible days in calculating factor 3 of the Provider’s uncompensated care (“UCC”) payment was lawful?

Issue 2: Whether CMS erred and acted beyond its authority, i.e., ultra vires, by failing to effectuate the D.C. circuit’s *Allina* decision when it calculated factor 3 in the Provider’s UCC payment.<sup>2</sup>

For Issue 1, the Provider notes that it underwent a change in ownership and, as such, CMS used its Medicaid days from a 7.5 month<sup>3</sup> cost reporting period (“stub-period”) to calculate its UCC adjustment amount. It claims that CMS is statutorily required to calculate the UCC payment for each hospital “for a period selected by the Secretary,” and that comparing the days in a stub-period for the Provider to a full twelve-month period for other providers employs different “periods” in violation of that statutory requirement.<sup>4</sup> The Provider also argues that the use of a stub-period violates the statutory requirement that any “estimate” used by the Secretary be “based on appropriate data.”<sup>5</sup> They claim that this practice

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<sup>1</sup> Individual Appeal Request, Tab 1 (Feb. 2, 2015); 79 Fed. Reg. 49853 (Aug. 22, 2014).

<sup>2</sup> Individual Appeal Request, Tab 3 at 1-2.

<sup>3</sup> In Provider’s Jurisdictional Response, they note that CMS actually used a 9-month stub period. Provider’s Jurisdictional Response, 1 (July 2, 2018).

<sup>4</sup> *Id.* at 1.

<sup>5</sup> *Id.* at 1-2.

arbitrarily penalizes certain providers with “stub-periods.”<sup>6</sup> Finally, the Provider argues that it is not being provided the same protection afforded to Indian Health Service (“IHS”) hospitals. They note that, originally, because cost reports for IHS hospitals are not uploaded to HCRIS, the UCC payments calculated by CMS understated the amount of uncompensated care that IHS hospitals provide. CMS later revised its policy to consider supplemental cost report data in determining Factor 3 to allow the Medicaid days for HIS hospitals to be included.<sup>7</sup>

For Issue 2, the Provider discusses *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) (“*Allina*”) with regard to the calculation of Factor 3 of the UCC payment, reiterating the argument that SSI days should exclude Medicare Advantage (“MA”) days, and MA dual eligible days should be included as Medicaid days in the FY 2015 Factor 3 calculation. They point out CMS’ position that it does not believe *Allina* has any bearing on the estimate of Factor 3 for FY 2015 since it had re-adopted the policy of counting MA says in the SSI ration for FY 2014 and beyond. The Provider argues that this policy still relies on SSI and Medicaid data from a period predating this re-adopted policy, and that CMS was obligated to correct those numbers to confirm with the Court’s ruling in *Allina*. The Provider contends that this approach results in CMS acting beyond its authority by continuing to treat Part C days as “days entitled to benefits under Part A” for periods pre-dating their re-adopted policy.<sup>8</sup>

The Medicare Contractor (“MAC”) filed a Jurisdictional Challenge in this case on June 8, 2018. The MAC argues that both issues are precluded from administrative and judicial review pursuant to 42 U.S.C. § 1395ww(r)(3).<sup>9</sup> The MAC describes the Provider’s challenge as an argument that the Secretary’s determinations of the UCC DSH payments are not based on the best, most reliable data, and that such a challenge has been precluded by statute, as explained in the *Tampa General*<sup>10</sup> case.<sup>11</sup> Finally, the MAC states that the *Allina* case does not address the 2014 Medicare IPPS Rule that adopts a policy of counting Part C Days in the Medicare fraction, and as such does not support Provider’s arguments in this case.<sup>12</sup>

The Provider filed a Response to the MAC’s Jurisdictional Challenge on July 2, 2018. They argue that CMS failed to use “appropriate data” in calculating Factor 3 for their FY 2015 UCC DSH payment as required by § 1886(r) of the Social Security Act because their own policy required, when the 2012 cost report is for less than twelve months, they would use “the cost report from 2012 or 2011 that is closest to being a full 12-month cost report.”<sup>13</sup> They insist that they are not challenging the estimates made or time period selected in calculating Factor 3, but rather CMS’ failure to follow its own policy in calculating their Medicaid-eligible days.<sup>14</sup> Finally, the Provider states that CMS has acted *ultra vires* by counting patient days under Part C as “days entitled to benefits under Part A” in calculating its SSI ratio, contrary to the holding in *Allina*.<sup>15</sup>

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<sup>6</sup> *Id.* at 2.

<sup>7</sup> *Id.* See also 78 Fed. Reg. 61191, 61195 (Oct. 3, 2013).

<sup>8</sup> Individual Appeal Request, Tab 3 at 2-3. See also 79 Fed. Reg. 49853.

<sup>9</sup> Medicare Administrative Contractor’s Motion to Dismiss Issue for Lack of Subject Matter Jurisdiction, 3 (June 8, 2018) (hereinafter “MAC’s Jurisdictional Challenge”).

<sup>10</sup> *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec’y of Health & Human Servs.* (“*Tampa General*”), 830 F.3d 515 (D.C. Cir. 2016).

<sup>11</sup> MAC’s Jurisdictional Challenge at 4

<sup>12</sup> *Id.* at 5.

<sup>13</sup> Provider’s Jurisdictional Response at 1 (citing 79 Fed. Reg. 49854, 50019 (Aug. 22, 2014)).

<sup>14</sup> *Id.* at 4,

<sup>15</sup> Provider’s Jurisdictional Response at 2, 6.

**Board's Decision:**

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

- (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).<sup>16</sup>
- (B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court<sup>17</sup> upheld the D.C. District Court's decision<sup>18</sup> that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."<sup>19</sup> The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.<sup>20</sup>

The Board finds that the same findings are applicable to the Provider's challenge to their 2015 Uncompensated Care payments. As in *Tampa General*, the Provider here is challenging the calculation of the amount they received for uncompensated care for FY 2015. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Provider is seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board, therefore, finds that the Provider is challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying

<sup>16</sup> Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

<sup>17</sup> *Fla. Health Sciences Cir., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*<sup>17</sup> ("Tampa General"), 830 F.3d 515 (D.C. Cir. 2016).

<sup>18</sup> 89 F. Supp. 3d 121 (D.D.C. 2015).

<sup>19</sup> 830 F.3d 515, 517.

<sup>20</sup> *Id.* at 519.

data as well. Furthermore, in challenging the Medicare Contractor's use of a stub-period cost report covering one time period, rather than a twelve-month cost report covering a different period, the Provider is challenging the "period selected by the Secretary" used in creating those estimates, which is also barred from review.

It should be noted that CMS did, in fact, state that it would "use the 2012 cost report, *unless that cost report is unavailable or reflects less than a full 12-month year*. In the event the 2012 cost report is for less than 12 months, [CMS] would use the cost report from 2012 or 2011 that is closest to being a full 12-month cost report. In the case where a less than 12-month cost report was used to calculate a hospital's Factor 3, this would indicate that both the 2012 and 2011 cost reports were less than 12 months. In such a case [CMS] would use the longer of the two cost reports to calculate a hospital's Factor 3."<sup>21</sup> In this case, neither the Provider's Individual Appeal Request, nor its Response to the MAC's Jurisdictional Challenge, allege that there was, in fact, a longer cost report available to use. The Provider seems to simply be challenging the fact that they were forced to use a stub-period cost report, which is the time period selected by the Secretary for this scenario, which is barred from review.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in this group appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes the referenced group appeal and removes it from its docket.

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

Board Members Participating:

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

For the Board:

4/1/2019

 Clayton J. Nix

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

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

<sup>21</sup> 79 Fed. Reg. at 50019 (emphasis added).



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

Corinna Goron  
Healthcare Reimbursement Services, Inc.  
17101 Preston Road  
Suite 220  
Dallas, TX 75248

**RE: *EJR Determination***

14-3510G – HRS 2008 DSH SSI Fraction Medicare Managed Care Part C Days Group  
15-1966GC – HRS SCHS 2012 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Grp.  
14-3518G – HRS 2007 DSH SSI Fraction Medicare Managed Care Part C Days Group  
15-3256GC – HRS THR 2012 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Grp.  
15-3258GC – HRS THR 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP

Dear Ms. Goron:

The Provider Reimbursement Review Board (“PRRB” or “Board”) has reviewed the Providers’ March 12, 2019 request for expedited judicial review (“EJR”) of the above-referenced appeals. The Board’s jurisdictional determination and decision regarding the EJR request is set forth below.

**Issue in Dispute**

The issue in these appeals is:

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

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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<sup>1</sup> Providers’ EJR request at 1.

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (“DPP”).<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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.<sup>11</sup>

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<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> Emphasis added.

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

<sup>11</sup> Emphasis added.

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

### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

With the creation of Medicare Part C in 1997,<sup>16</sup> Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

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

days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.<sup>17</sup>

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

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

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

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

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

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<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

<sup>20</sup> *Id.* (emphasis added).



Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.<sup>21</sup> In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).<sup>22</sup> As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,<sup>23</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.<sup>24</sup> However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price (Allina II)*,<sup>25</sup> the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>26</sup> The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>27</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers’ Request for EJR**

The Providers explain that “[b]ecause the Secretary has not acquiesced to the decision in *Allina*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (‘The 2004 Rule’) The Board is bound by the 2004 rule.”<sup>28</sup> Accordingly, the Providers contend that the Board should grant their request for EJR.

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

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<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> *Id.* at 47411.

<sup>23</sup> 746 F.3d 1102 (D.C. Cir. 2014).

<sup>24</sup> *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>25</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>26</sup> *Id.* at 943.

<sup>27</sup> *Id.* at 943-945.

<sup>28</sup> Providers’ EJR Request at 1.

## **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.

### **Improper Inclusion of Previously-Dismissed Providers on the Schedule of Providers**

At the outset, the Board notes that each of the Schedule of Providers that the Providers' representative submitted with the EJR request for Case Nos. 15-1966GC and 14-3518G **improperly** include a Provider that the Board has either previously dismissed or denied a transfer to a group appeal. Specifically, the Board previously dismissed the individual appeal for Provider 42-0026 (Providence Hospitals), FYE 12/31/2012, for lack of jurisdiction<sup>29</sup> and, thus, this Provider's individual appeal is not currently part of Case No. 15-1966GC. In addition, the Board previously ruled **multiple** times that Provider 20-0024 (Central Maine Medical Center), FYE 6/30/2007, did not properly add the Part C Days issue to its individual appeal<sup>30</sup> and, thus, the Board has denied **multiple** times the Provider's request to transfer the issue to Case No. 14-3518G. Accordingly, these two Providers are **not** currently part of Case Nos. 15-1966GC and 14-3518G and, as such, the Board can **not** consider them as part of this EJR request (notwithstanding the Provider representative's **improper** attempt to include these Providers on the Schedule of Providers for these two group appeals). The Board will address the Provider Representative's failure to comply with Board Rules under separate cover pursuant to 42 C.F.R. § 405.1868.

### **Jurisdiction for the Current Remaining Participants**

The participants that currently comprise the group appeals within this EJR request have filed appeals involving fiscal years 2007, 2008 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 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)*.<sup>31</sup> 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.

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<sup>29</sup> See Board correspondence dated July 9, 2015 regarding the individual appeal under the Case No. 15-0481.

<sup>30</sup> See Board correspondence dated April 10, 2014, July 10, 2014, and December 17, 2014 regarding the individual appeal under Case No. 14-1712.

<sup>31</sup> 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.).

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.<sup>32</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>33</sup> 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*”).<sup>34</sup> 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.<sup>35</sup>

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant’s appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>36</sup> The Board notes that all participant with revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the current remaining participants’ appeals involved with the instant EJR Request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R and that the participant appeals filed from a revised NPR have the appropriate adjustment to the Part C days issue within the revised NPR. In addition, the participants’ documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal<sup>37</sup> and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly,

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<sup>32</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>33</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>34</sup> 201 F. Supp. 3d 131 (D.D.C. 2016)

<sup>35</sup> *Id.* at 142.

<sup>36</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

<sup>37</sup> See 42 C.F.R. § 405.1837.

the Board finds that it has jurisdiction for the above-captioned appeals and the current remaining participants.

*Board's Analysis Regarding the Appealed Issue*

The appeals remaining in these EJR requests involve the 2007, 2008 and 2012 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>38</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>39</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

*Board's Decision Regarding the EJR Request*

The Board finds that:

- 1) Providence Hospital Sisters of Charity, Provider No. 42-0026, is not part of the EJR request for Case No. 15-1966GC and Central Maine Medical Center, Provider No. 20-0024, is not part of the EJR request for Case No. 14-3518G because the Board had previously dismissed, in pertinent part, each provider and, accordingly, from that time on, each provider was not in (and could no longer be a part of) the respective group appeal;
- 2) It has jurisdiction over the matter for the subject years and that the currently remaining participants in these group appeals are entitled to a hearing before the Board;
- 3) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 4) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 5) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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<sup>38</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>39</sup> See 42 U.S.C. § 1395oo(f)(1).

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the current remaining participants' request for EJR for the issue and the subject years (*i.e.*, this grant does not include the two providers as noted above that had been previously dismissed). These participants have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes those cases.

Board Members Participating:

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

For the Board:

4/1/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers for Case Nos. 14-3510GC, *et al.*

cc: Lorraine Frewert, Noridian (Electronic Mail w/Schedules of Providers)  
Judith Cummings, CGS (Electronic Mail w/Schedules of Providers)  
Bruce Snyder, Novitas Solutions, Inc. (Electronic Mail w/Schedules of Providers)  
Bill Tisdale, Novitas Solutions, Inc. (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Provider Reimbursement Review Board  
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Daniel Hettich  
King & Spalding, LLP  
1700 Pennsylvania Avenue, Suite 200  
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**RE: *Jurisdictional Decision***  
Moses Taylor Hospital (39-0119)  
PRRB Case 15-1297

Dear Mr. Hettich,

The Provider Reimbursement Review Board (“Board”) has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

**Pertinent Facts:**

The Provider filed their appeal request on January 30, 2015, challenging the Final Rule in the Federal Register issued on August 22, 2014.<sup>1</sup> The Provider’s appeal focuses on whether its DSH payment contained a calculation error related to the third factor (“Factor 3”) used to determine the payment for its proportion of uncompensated care. Specifically, the Provider has framed two issues as follows:

Issue 1: Whether CMS’s failure to use a full 12-month cost reporting period to determine the number of the Provider’s Medicaid eligible days in calculating factor 3 of the Provider’s uncompensated care (“UCC”) payment was lawful?

Issue 2: Whether CMS erred and acted beyond its authority, *i.e.*, *ultra vires*, by failing to effectuate the D.C. circuit’s *Allina* decision when it calculated factor 3 in the Provider’s UCC payment.<sup>2</sup>

For Issue 1, the Provider notes that it underwent a change in ownership and, as such, CMS used its Medicaid days from a shortened cost reporting period (“stub-period”) to calculate its UCC adjustment amount. It claims that CMS is statutorily required to calculate the UCC payment for each hospital “for a period selected by the Secretary,” and that comparing the days in a stub-period for the Provider to a full twelve-month period for other providers employs different “periods” in violation of that statutory requirement.<sup>3</sup> The Provider also argues that the use of a stub-period violates the statutory requirement that any “estimate” used by the Secretary be “based on appropriate data.”<sup>4</sup> They claim that this practice arbitrarily penalizes certain providers with “stub-periods.”<sup>5</sup> Finally, the Provider argues that it is not being provided the same protection afforded to Indian Health Service (“IHS”) hospitals. They note that,

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<sup>1</sup> Individual Appeal Request, Tab 1 (Jan. 30, 2015); 79 Fed. Reg. 49853 (Aug. 22, 2014).

<sup>2</sup> Individual Appeal Request, Tab 3 at 1-3.

<sup>3</sup> *Id.* at 1.

<sup>4</sup> *Id.* at 1-2.

<sup>5</sup> *Id.* at 2.

originally, because cost reports for IHS hospitals are not uploaded to HCRIS, the UCC payments calculated by CMS understated the amount of uncompensated care that IHS hospitals provide. CMS later revised its policy to consider supplemental cost report data in determining Factor 3 to allow the Medicaid days for HIS hospitals to be included.<sup>6</sup>

For Issue 2, the Provider discusses *Allina Health Servs. V. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) (“*Allina*”) with regard to the calculation of Factor 3 of the UCC payment, reiterating the argument that SSI days should exclude Medicare Advantage (“MA”) days, and MA dual eligible days should be included as Medicaid days in the FY 2015 Factor 3 calculation. They point out CMS’ position that it does not believe *Allina* has any bearing on the estimate of Factor 3 for FY 2015 since it had readopted the policy of counting MA says in the SSI ration for FY 2014 and beyond. The Provider argues that this policy still relies on SSI and Medicaid data from a period predating this re-adopted policy, and that CMS was obligated to correct those numbers to confirm with the Court’s ruling in *Allina*. The Provider contends that this approach results in CMS acting beyond its authority by continuing to treat Part C days as “days entitled to benefits under Part A” for periods pre-dating their re-adopted policy.<sup>7</sup>

The Medicare Contractor (“MAC”) filed a Jurisdictional Challenge in this case on June 8, 2018. The MAC argues that both issues are precluded from administrative and judicial review pursuant to 42 U.S.C. § 1395ww(r)(3).<sup>8</sup> The MAC describes the Provider’s challenge as an argument that the Secretary’s determinations of the UCC DSH payments are not based on the best, most reliable data, and that such a challenge has been precluded by statute, as explained in the *Tampa General*<sup>9</sup> case.<sup>10</sup> Finally, the MAC states that the *Allina* case does not address the 2014 Medicare IPPS Rule that adopts a policy of counting Part C Days in the Medicare fraction, and as such does not support Provider’s arguments in this case.<sup>11</sup>

The Provider filed a Response to the MAC’s Jurisdictional Challenge on July 2, 2018. They argue that CMS failed to use “appropriate data” in calculating Factor 3 for their FY 2015 UCC DSH payment as required by § 1886(r) of the Social Security Act because their own policy required, when the 2012 cost report is for less than twelve months, they would use “the cost report from 2012 or 2011 that is closest to being a full 12-month cost report.”<sup>12</sup> They insist that they are not challenging the estimates made or time period selected in calculating Factor 3, but rather CMS’ failure to follow its own policy in calculating their Medicaid-eligible days.<sup>13</sup> Finally, the Provider states that CMS has acted *ultra vires* by counting patient days under Part C as “days entitled to benefits under Part A” in calculating its SSI ratio, contrary to the holding in *Allina*.<sup>14</sup>

<sup>6</sup> *Id.* See also 78 Fed. Reg. 61191, 61195 (Oct. 3, 2013).

<sup>7</sup> Individual Appeal Request, Tab 3 at 2-3. See also 79 Fed. Reg. 49853.

<sup>8</sup> Medicare Administrative Contractor’s Motion to Dismiss Issue for Lack of Subject Matter Jurisdiction, 3 (June 8, 2018) (hereinafter “MAC’s Jurisdictional Challenge”).

<sup>9</sup> *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec’y of Health & Human Servs.* (“*Tampa General*”), 830 F.3d 515 (D.C. Cir. 2016). At the

<sup>10</sup> MAC’s Jurisdictional Challenge at 4

<sup>11</sup> *Id.* at 5.

<sup>12</sup> Provider’s Jurisdictional Response at 1 (citing 79 Fed. Reg. 49854, 50019 (Aug. 22, 2014)).

<sup>13</sup> *Id.* at 4.

<sup>14</sup> Provider’s Jurisdictional Response at 2, 6.

**Board's Decision:**

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

- (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).<sup>15</sup>
- (B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court<sup>16</sup> upheld the D.C. District Court's decision<sup>17</sup> that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."<sup>18</sup> The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.<sup>19</sup>

The Board finds that the same findings are applicable to the Provider's challenge to their 2015 Uncompensated Care payments. As in *Tampa General*, the Provider here is challenging the calculation of the amount they received for uncompensated care for FY 2015. The Board finds that, in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Provider is seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board, therefore, finds that the Provider is challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying

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<sup>15</sup> Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

<sup>16</sup> *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*<sup>16</sup> ("Tampa General"), 830 F.3d 515 (D.C. Cir. 2016).

<sup>17</sup> 89 F. Supp. 3d 121 (D.D.C. 2015).

<sup>18</sup> 830 F.3d 515, 517.

<sup>19</sup> *Id.* at 519.



data as well. Furthermore, in challenging the Medicare Contractor's use of a stub-period cost report covering one time period, rather than a twelve-month cost report covering a different period, the Provider is challenging the "period selected by the Secretary" used in creating those estimates, which is also barred from review.

It should be noted that CMS did, in fact, state that it would "use the 2012 cost report, *unless that cost report is unavailable or reflects less than a full 12-month year*. In the event the 2012 cost report is for less than 12 months, [CMS] would use the cost report from 2012 or 2011 that is closest to being a full 12-month cost report. In the case where a less than 12-month cost report was used to calculate a hospital's Factor 3, this would indicate that both the 2012 and 2011 cost reports were less than 12 months. In such a case [CMS] would use the longer of the two cost reports to calculate a hospital's Factor 3."<sup>20</sup> For FY 2015, CMS used data from the December 2013 update to the HCRIS database for cost reporting periods beginning in either FY 2011 or FY 2012.<sup>21</sup>

Due to a change in ownership, the Provider claims that it has two cost reports beginning in 2012: January 1, 2012 through June 30, 2012, and July 1, 2012, through June 30, 2013.<sup>22</sup> They argue that, since one does not represent a full twelve-month cost reporting period, and the other does, that the latter should have been used when determining its Medicaid eligible days.<sup>23</sup> It is not clear whether the second, full, cost report data had been uploaded by the MAC to HCRIS when Provider's Factor 3 was calculated, since the data from the December 2013 HCRIS update was used in calculating Factor 3, and the MAC had up to 210 days after the cost reporting period ending date to upload it, which would have been in January 26, 2014.<sup>24</sup> It would appear that the Provider is alleging that more recent data should have been used, which was the argument rejected in *Tampa General*.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in this group appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes the referenced group appeal and removes it from its docket.

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

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Robert A. Evarts, Esq.  
Susan A. Turner, Esq.

For the Board:

4/1/2019

X Clayton J. Nix

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

<sup>20</sup> 79 Fed. Reg. at 50019 (emphasis added).

<sup>21</sup> *Id.* at 50018.

<sup>22</sup> Provider's Jurisdictional Response at 1.

<sup>23</sup> *Id.*

<sup>24</sup> 79 Fed. Reg. at 50019.

Moses Taylor Hospital (39-0119)

PRRB Case No.: 15-1297

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cc: Wilson C. Leong, Esq., Federal Specialized Services  
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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**RE: *Jurisdictional Decision***  
Tomball Regional Center (45-0670)  
PRRB Case 15-1296

Dear Mr. Hettich,

The Provider Reimbursement Review Board (“Board”) has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the Uncompensated Care Payment issue. The jurisdictional decision of the Board is set forth below.

**Pertinent Facts:**

The Provider filed their appeal request on January 30, 2015, challenging the Final Rule in the Federal Register issued on August 22, 2014.<sup>1</sup> The Provider’s appeal focuses on whether its DSH payment contained a calculation error related to the third factor (“Factor 3”) used to determine the payment for its proportion of uncompensated care. Specifically, the Provider has framed two issues as follows:

*Issue 1:* Whether CMS’s failure to use a full 12-month cost reporting period to determine the number of the Provider’s Medicaid eligible days in calculating factor 3 of the Provider’s uncompensated care (“UCC”) payment was lawful?

*Issue 2:* Whether CMS erred and acted beyond its authority, *i.e.*, *ultra vires*, by failing to effectuate the D.C. circuit’s *Allina* decision when it calculated factor 3 in the Provider’s UCC payment.<sup>2</sup>

For Issue 1, the Provider notes that it underwent a change in ownership and, as such, CMS used its Medicaid days from a shortened cost reporting period (“stub-period”) to calculate its UCC adjustment amount. It claims that CMS is statutorily required to calculate the UCC payment for each hospital “for a period selected by the Secretary,” and that comparing the days in a stub-period for the Provider to a full twelve-month period for other providers employs different “periods” in violation of that statutory requirement.<sup>3</sup> The Provider also argues that the use of a stub-period violates the statutory requirement that any “estimate” used by the Secretary be “based on appropriate data.”<sup>4</sup> They claim that this practice arbitrarily penalizes certain providers with “stub-periods.”<sup>5</sup> Finally, the Provider argues that it is not being provided the same protection afforded to Indian Health Service (“IHS”) hospitals. They note that,

<sup>1</sup> Individual Appeal Request, Tab 1 (Jan. 30, 2015); 79 Fed. Reg. 49853 (Aug. 22, 2014).

<sup>2</sup> Individual Appeal Request, Tab 3 at 1-3.

<sup>3</sup> *Id.* at 1.

<sup>4</sup> *Id.* at 1-2.

<sup>5</sup> *Id.* at 2.

originally, because cost reports for IHS hospitals are not uploaded to HCRIS, the UCC payments calculated by CMS understated the amount of uncompensated care that IHS hospitals provide. CMS later revised its policy to consider supplemental cost report data in determining Factor 3 to allow the Medicaid days for HIS hospitals to be included.<sup>6</sup>

For Issue 2, the Provider discusses *Allina Health Servs. V. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) (“*Allina*”) with regard to the calculation of Factor 3 of the UCC payment, reiterating the argument that SSI days should exclude Medicare Advantage (“MA”) days, and MA dual eligible days should be included as Medicaid days in the FY 2015 Factor 3 calculation. They point out CMS’ position that it does not believe *Allina* has any bearing on the estimate of Factor 3 for FY 2015 since it had readopted the policy of counting MA says in the SSI ration for FY 2014 and beyond. The Provider argues that this policy still relies on SSI and Medicaid data from a period predating this re-adopted policy, and that CMS was obligated to correct those numbers to confirm with the Court’s ruling in *Allina*. The Provider contends that this approach results in CMS acting beyond its authority by continuing to treat Part C days as “days entitled to benefits under Part A” for periods pre-dating their re-adopted policy.<sup>7</sup>

The Medicare Contractor (“MAC”) filed a Jurisdictional Challenge in this case on June 8, 2018. The MAC argues that both issues are precluded from administrative and judicial review pursuant to 42 U.S.C. § 1395ww(r)(3).<sup>8</sup> The MAC describes the Provider’s challenge as an argument that the Secretary’s determinations of the UCC DSH payments are not based on the best, most reliable data, and that such a challenge has been precluded by statute, as explained in the *Tampa General*<sup>9</sup> case.<sup>10</sup> Finally, the MAC states that the *Allina* case does not address the 2014 Medicare IPPS Rule that adopts a policy of counting Part C Days in the Medicare fraction, and as such does not support Provider’s arguments in this case.<sup>11</sup>

The Provider filed a Response to the MAC’s Jurisdictional Challenge on July 2, 2018. They argue that CMS failed to use “appropriate data” in calculating Factor 3 for their FY 2015 UCC DSH payment as required by § 1886(r) of the Social Security Act because their own policy required, when the 2012 cost report is for less than twelve months, they would use “the cost report from 2012 or 2011 that is closest to being a full 12-month cost report.”<sup>12</sup> They insist that they are not challenging the estimates made or time period selected in calculating Factor 3, but rather CMS’ failure to follow its own policy in calculating their Medicaid-eligible days.<sup>13</sup> Finally, the Provider states that CMS has acted *ultra vires* by counting patient days under Part C as “days entitled to benefits under Part A” in calculating its SSI ratio, contrary to the holding in *Allina*.<sup>14</sup>

<sup>6</sup> *Id.* See also 78 Fed. Reg. 61191, 61195 (Oct. 3, 2013).

<sup>7</sup> Individual Appeal Request, Tab 3 at 2-3. See also 79 Fed. Reg. 49853.

<sup>8</sup> Medicare Administrative Contractor’s Motion to Dismiss Issue for Lack of Subject Matter Jurisdiction, 3 (June 8, 2018) (hereinafter “MAC’s Jurisdictional Challenge”).

<sup>9</sup> *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec’y of Health & Human Servs.* (“*Tampa General*”), 830 F.3d 515 (D.C. Cir. 2016). At the

<sup>10</sup> MAC’s Jurisdictional Challenge at 4

<sup>11</sup> *Id.* at 5.

<sup>12</sup> Provider’s Jurisdictional Response at 1 (citing 79 Fed. Reg. 49854, 50019 (Aug. 22, 2014)).

<sup>13</sup> *Id.* at 4.

<sup>14</sup> Provider’s Jurisdictional Response at 2, 6.

**Board's Decision:**

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

- (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).<sup>15</sup>
- (B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court<sup>16</sup> upheld the D.C. District Court's decision<sup>17</sup> that there is no judicial or administrative review of uncompensated care DSII payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."<sup>18</sup> The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.<sup>19</sup>

The Board finds that the same findings are applicable to the Provider's challenge to their 2015 Uncompensated Care payments. As in *Tampa General*, the Provider here is challenging the calculation of the amount they received for uncompensated care for FY 2015. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Provider is seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board, therefore, finds that the Provider is challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying

<sup>15</sup> Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

<sup>16</sup> *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*<sup>16</sup> ("Tampa General"), 830 F.3d 515 (D.C. Cir. 2016).

<sup>17</sup> 89 F. Supp. 3d 121 (D.D.C. 2015).

<sup>18</sup> 830 F.3d 515, 517.

<sup>19</sup> *Id.* at 519.

data as well. Furthermore, in challenging the Medicare Contractor's use of a stub-period cost report covering one time period, rather than a twelve-month cost report covering a different period, the Provider is challenging the "period selected by the Secretary" used in creating those estimates, which is also barred from review.

It should be noted that CMS did, in fact, state that it would "use the 2012 cost report, *unless that cost report is unavailable or reflects less than a full 12-month year*. In the event the 2012 cost report is for less than 12 months, [CMS] would use the cost report from 2012 or 2011 that is closest to being a full 12-month cost report. In the case where a less than 12-month cost report was used to calculate a hospital's Factor 3, this would indicate that both the 2012 and 2011 cost reports were less than 12 months. In such a case [CMS] would use the longer of the two cost reports to calculate a hospital's Factor 3."<sup>20</sup> For FY 2015, CMS used data from the December 2013 update to the HCRIS database for cost reporting periods beginning in either FY 2011 or FY 2012.<sup>21</sup>

Due to a change in ownership, the Provider claims that it has two relevant cost reports: October 1, 2011 through June 30, 2012, and July 1, 2012, through June 20, 2013.<sup>22</sup> They argue that, since one does not represent a full twelve-month cost reporting period, and the other does, that the latter should have been used when determining its Medicaid eligible days.<sup>23</sup> It is not clear whether the second, full, cost report was "unavailable" or whether the data had been uploaded by the MAC to HCRIS, since the data from the December 2013 update was used in calculating Factor 3, and the MAC had up to 210 days after the cost reporting period ending date to upload it, which would have been in January 26, 2014.<sup>24</sup> It would appear that the Provider is alleging that more recent data should have been used, which was the argument rejected in *Tampa General*.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in this group appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes the referenced group appeal and removes it from its docket.

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

Board Members Participating:

Clayton J. Nix, Esq.  
Charlotte F. Benson, CPA  
Gregory H. Ziegler, CPA, CPC-A  
Robert A. Evarts, Esq.  
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For the Board:

1 4/1/2019

**X** Clayton J. Nix

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

<sup>20</sup> 79 Fed. Reg. at 50019 (emphasis added).

<sup>21</sup> *Id.* at 50018.

<sup>22</sup> Provider's Jurisdictional Response at 1.

<sup>23</sup> *Id.*

<sup>24</sup> 79 Fed. Reg. at 50019.

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cc: Wilson C. Leong, Esq., Federal Specialized Services  
Bill Tisdale, Novitas Solutions, Inc. (J-H)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board  
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**Electronic Delivery**

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

16-1751G QRS 2012 DSH Medicaid Fraction Medicare Managed Care Part C  
16-1753G QRS 2012 DSH SSI Fraction Medicare Managed Care Part C Days  
17-1404G QRS 2013 DSH SSI Fraction Medicare Managed Care Part C Days  
17-1430G QRS 2013 DSH Medicaid Fraction Medicare Managed Care Part C

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ February 1, 2019 request for expedited judicial review (“EJR”),<sup>1</sup> as well as the Providers’ March 14, 2019 response to the Board’s February 28, 2019 letter requesting additional information required to act upon the EJR submission. In its February 28<sup>th</sup> letter, the Board requested that the Providers clearly identify the legal authority they were challenging and how it is binding on the Board, making EJR appropriate. The Board’s determination regarding both jurisdiction and EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

[W]hether Medicare Advantage Days (“Part C Days”) should be removed from the disproportionate share hospital adjustment (“DSH Adjustment”) Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of

<sup>1</sup> This determination is one of several that will be issued in response to the four EJR requests that were filed on February 1, 2019 and March 14, 2019, involving 28 cases and approximately 680 individual Provider jurisdictional determinations.



Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).<sup>2</sup>

### **Statutory and Regulatory Background: Medicare DSH Payment**

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>7</sup> 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.<sup>8</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>9</sup> 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 . . . .<sup>10</sup>

<sup>2</sup> Providers' EJR request at 1.

<sup>3</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>4</sup> *Id.*

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>6</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>8</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>9</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>10</sup> (Emphasis added.)

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

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.<sup>12</sup>

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.<sup>13</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>14</sup> stated that:

Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment].

<sup>11</sup> 42 C.F.R. § 412.106(b)(2)-(3).

<sup>12</sup> (Emphasis added.)

<sup>13</sup> 42 C.F.R. § 412.106(b)(4).

<sup>14</sup> of Health and Human Services.

However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].<sup>15</sup>

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>16</sup>

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

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

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

The Secretary purportedly changed her position in the Federal fiscal year (“FFY”) 2005 IPPS final rule, by noting she was “revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to

<sup>15</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>16</sup> *Id.*

<sup>17</sup> The Medicare Part C program did not begin operating until January 1, 1999. See P.L. 105-33, 1997 HR 2015, codified as 42 U.S.C. § 1394w-21 Note (c) “Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . .” This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

<sup>18</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>19</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation.”<sup>20</sup> In response to a comment regarding this change, the Secretary explained that:

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

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.<sup>22</sup> In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).<sup>23</sup> As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) “to clarify” the Part C DSH policy by replacing the word “or” with “including.”<sup>24</sup>

<sup>20</sup> 69 Fed. Reg. at 49099.

<sup>21</sup> *Id.* (emphasis added).

<sup>22</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>23</sup> 72 Fed. Reg. at 47411.

<sup>24</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,<sup>25</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.<sup>26</sup> However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price ("Allina IP")*,<sup>27</sup> the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>28</sup> The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>29</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers' Request for EJR**

The Providers contend that "[b]ecause the Secretary has not acquiesced to the decision in *Allina II*, the 2004 regulation requiring Part C Days to be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R.

§§ 405.106(b)(2)(I)(B) and (b)(2)(iii)(B). (The '2004 Rule) The Board is bound by the 2004 Rule."<sup>30</sup> The Providers contend that the pre-2004 version of the DSH regulation should remain in place, providing that the numerator of the DSH fraction include only "covered patient days that . . . are furnished to patients who, during that month were entitled to both Medicare Part A and SSI."<sup>31</sup>

The Providers believe that the Board is without the authority to grant the relief they are seeking: an order that Part C Days should be excluded from the Part A/SSI fraction and included in the numerator of the Medicaid fraction. Consequently, they contend EJR is appropriate.

### **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.

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<sup>25</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>26</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

<sup>27</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>28</sup> *Id.* at 943.

<sup>29</sup> *Id.* at 943-945.

<sup>30</sup> Providers' Revised EJR Request at 1.

<sup>31</sup> 42 C.F.R. § 412.106(b)(2)(i)(2003).

### Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2012-2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").<sup>32</sup> 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.<sup>33</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>34</sup> 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*").<sup>35</sup> 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.<sup>36</sup>

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

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<sup>32</sup> 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.).

<sup>33</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>34</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>35</sup> 201 F. Supp. 3d 131 (D.D.C. 2016)

<sup>36</sup> *Id.* at 142.

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 participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal<sup>37</sup> and \$10,000 for the individual appeals.<sup>38</sup> The appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers.

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2012 and 2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>39</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>40</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.<sup>41</sup>

#### Board's Decision Regarding the EJR Request

The Board finds that:

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

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<sup>37</sup> See 42 C.F.R. § 405.1837.

<sup>38</sup> See 42 C.F.R. § 405.1835.

<sup>39</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>40</sup> See 42 U.S.C. § 1395oo(f)(1).

<sup>41</sup> One of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in a number of cases identified in the EJR request. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the D.C. Federal District Court vacated in *Allina I*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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

Board Members Participating:

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

FOR THE BOARD:

4/2/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS (Electronic Mail w/Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)





**Electronic Delivery**

Stephanie Webster  
Akin Gump Strauss Hauer & Feld, LLP  
1333 New Hampshire Avenue, NW  
Washington, DC 20036-1564

**RE: *EJR Determination***

- 13-0954GC, Sanford Health System 2010 SSI Part C Days CIRP Group;
- 13-2761GC, Sanford 2007 Post 1498R SSI Part C Days CIRP Group;
- 13-3508GC, Sanford HS 2008 SSI Part C Days CIRP Group;
- 13-3511GC, Sanford HS 2008 Medicaid Fraction Part C Days CIRP Group
- 14-0987GC, Sanford 2009 SSI Part C Days CIRP Group;
- 14-0989GC, Sanford 2009 Medicaid Fraction Part C Days CIRP Group;
- 14-4013GC, Sanford Health 2011 DSH SSI Fraction Part C Days Group; and
- 14-4014GC, Sanford Health 2011 DSH Medicaid Fraction Part C Days Group

Dear Ms. Webster:

The Provider Reimbursement Review Board (“PRRB” or “Board”) has reviewed the Providers’ March 14, 2019 request for expedited judicial review (“EJR”) of the above-referenced appeals. The Board’s jurisdictional determination and decision regarding the EJR request is set forth below.

**Issue in Dispute**

The issue in these appeals is:

[W]hether “enrollees in Part C are ‘entitled to benefits’ under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction, or whether, if not regarded as ‘entitled to benefits under Part A,’ they should instead be included in the Medicaid fraction” of the DSH adjustment.<sup>1</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

<sup>1</sup> Providers’ EJR request at 4.

prospective payment system ("PPS").<sup>2</sup> Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.<sup>3</sup>

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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*

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> Emphasis added.

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

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

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.<sup>12</sup>

### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

With the creation of Medicare Part C in 1997,<sup>16</sup> Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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<sup>11</sup> Emphasis added.

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

<sup>16</sup> The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . ." This was also known as

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.<sup>17</sup>

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

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

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

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

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

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Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

<sup>20</sup> *Id.* (emphasis added).

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.<sup>21</sup> In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R.

§§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).<sup>22</sup> As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) “to clarify” the Part C DSH policy by replacing the word “or” with “including.”<sup>23</sup>

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

### **Providers’ Request for EJR**

The Providers essentially explain that because the Secretary has not acquiesced to the decision in *Allina I*, the FY 2005 IPPS final rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R.

§§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (“the 2004 Rule”). As the Board is otherwise bound by the 2004 rule, the Providers contend that the Board should grant their request for EJR.

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> *Id.* at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

<sup>28</sup> *Id.* at 943-945.

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

### **Decision of the Board**

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

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2007-2011.

For purposes of Board jurisdiction over a participant’s appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a “self-disallowed cost,” pursuant to the Supreme Court’s reasoning set out in *Bethesda Hospital Association v. Bowen* (“*Bethesda*”).<sup>29</sup> 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.<sup>30</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>31</sup> 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*”).<sup>32</sup> In *Banner*, the provider filed its cost report in accordance with the applicable

<sup>29</sup> 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.).

<sup>30</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>31</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>32</sup> 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.<sup>33</sup>

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>34</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

#### *Jurisdictional Determination for Participants*

The Board has determined that the participants' appeals involved with the instant EJR Request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R and that the appeals filed from a revised NPR contain the appropriate adjustment to the Part C days issue. In addition, the participants' documentation shows that the participants have met the required amount in controversy<sup>35</sup> for a hearing before the Board and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction to hear the above-captioned appeals for all group participants.

#### *Board's Analysis Regarding the Appealed Issue*

The appeals in these EJR requests involve the 2007-2011 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board

<sup>33</sup> *Id.* at 142.

<sup>34</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

<sup>35</sup> See 42 C.F.R. § 405.1837. Although Board Rule 12.6 (August 29, 2018) states that a group appeal must contain a minimum of two different providers, for administrative efficiency sake, the group appeals within this EJR Request that contain only one provider will be treated as individual appeals but retain the "group appeal" case number and name.

recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>36</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJRs, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>37</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPSS final rule are valid.

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

Board Members Participating:

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

For the Board:

4/2/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

<sup>36</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>37</sup> See 42 U.S.C. § 1395oo(f)(1).



cc: John Bloom, Noridian (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

Corinna Goron  
Healthcare Reimbursement Services, Inc.  
17101 Preston Road  
Suite 220  
Dallas, TX 75248

**RE: EJR Determination**

15-0673GC HRS/FMLOHS 2012 DSH SSI Fraction Medicare Mngd Care Part C Days Grp  
15-0674GC HRS/FMLOHS 2012 DSH Medicaid Fraction Medicare Mngd Care Part C Days Grp  
16-0977GC HRS/ProMedica H Sys 2013 DSH SSI Fraction Medicare Mngd Care Part C Days Grp  
16-0978GC HRS/ProMedica H Sys 2013 DSH Medicaid Fraction Medicare Mngd Care Part C Days  
16-1549GC HRS/THR 2013 DSH SSI Fraction Medicare Mngd Care Part C Days Grp  
16-1550GC HRS/THR 2013 DSH Medicaid Fraction Medicare Mngd Care Part C Days Grp  
16-2438GC HRS/LSU 2013 DSH Medicaid Fraction Medicare Mngd Care Part C Days Grp  
16-2440GC HRS/LSU 2013 DSH SSI Fraction Medicare Mngd Care Part C Days Grp

Dear Ms. Goron:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ March 7, 2019 request for expedited judicial review (“EJR”) for the appeals referenced above. The Board’s determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

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

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<sup>1</sup> Providers’ EJR request at 1.

### **Statutory and Regulatory Background: Medicare DSH Payment**

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> (Emphasis added.)

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

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

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

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.<sup>12</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

<sup>11</sup> (Emphasis added.)

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

including HMO days in the SSI/Medicare percentage [of the DSH adjustment].<sup>14</sup>

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

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

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

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

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

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

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

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

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

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

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

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<sup>20</sup> *Id.* (emphasis added).

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> 72 Fed. Reg. at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

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

### **Providers’ Request for EJR**

The Providers explain that “[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The ‘2004 Rule’) The Board is bound by the 2004 rule.”<sup>29</sup> Accordingly, the Providers contend that the Board should grant their request for EJR.

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

### **Decision of the Board**

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

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<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

<sup>28</sup> *Id.* at 943-945.

<sup>29</sup> Providers’ EJR Request at 1.

## Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2012 and 2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").<sup>30</sup> 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.<sup>31</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>32</sup> 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*").<sup>33</sup> 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.<sup>34</sup>

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016. Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on

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<sup>30</sup> 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.).

<sup>31</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>32</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>33</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>34</sup> *Id.* at 142.



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 participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>35</sup> The appeals 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 in each case.

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2012 and 2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>36</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>37</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

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<sup>35</sup> See 42 C.F.R. § 405.1837.

<sup>36</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>37</sup> See 42 U.S.C. § 1395oo(f)(1).

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

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

Board Members Participating:

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

FOR THE BOARD:

4/2/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Bill Tisdale, Novitas (Electronic Mail w/Schedules of Providers)  
Judith Cummings, CGS Administrators (Electronic Mail w/Schedules of Providers)  
Wilson Leong, (Electronic Mail w/Schedules of Providers)



**Electronic Delivery**

James Ravindran  
Quality Reimbursement Services, Inc.  
150 N. Santa Anita Avenue  
Suite 570A  
Arcadia, CA 91006

RE: ***Expedited Judicial Review Determination for PRRB Case Numbers:***

- 13-2995GC QRS HMA 2006 DSH Medicare Managed Care Part C Days CIRP Group (2)
- 13-3075GC QRS HMA 2007 DSH Medicare Managed Care Part C Days CIRP Group (2)
- 13-2329GC QRS HMA 2008 DSH Medicare Managed Care Part C Days Group
- 13-2325GC QRS HMA 2009 DSH Medicare Managed Care Part C Days CIRP Group
- 11-0792GC QRS HMA 2009 DSH SSI Medicare Part C Days Group
- 14-1077GC QRS HMA 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days Grp
- 14-1075GC QRS HMA 2010 DSH SSI Fraction Medicare Managed Care Part C Days Grp
- 15-1621GC QRS HMA 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days Grp
- 15-1619GC QRS HMA 2011 DSH SSI Fraction Medicare Managed Care Part C Days Grp
- 15-0587GC QRS HMA 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days Grp
- 15-0585GC QRS HMA 2012 DSH SSI Fraction Medicare Managed Care Part C Days Grp
- 16-0681GC QRS HMA 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days Grp
- 16-0680GC QRS HMA 2013 DSH SSI Fraction Medicare Managed Care Part C Days Grp

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“PRRB” or “Board”) has reviewed the Providers’ March 8, 2019 request for expedited judicial review (“EJR”) of the above referenced appeals. The Board’s jurisdictional determination and decision regarding the EJR request is set forth below.

**Issue in Dispute**

The issue in these appeals is:

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

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<sup>1</sup> Providers’ EJR request at 1.

### **Statutory and Regulatory Background: Medicare DSH Payment**

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> Emphasis added.

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

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

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

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.<sup>12</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

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<sup>11</sup> Emphasis added.

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

including HMO days in the SSI/Medicare percentage [of the DSH adjustment].<sup>14</sup>

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

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

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

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

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

*We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the*

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

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

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction.* We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.<sup>20</sup>

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (“*Allina I*”),<sup>24</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.<sup>25</sup> However, the Secretary has not acquiesced to that decision.

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<sup>20</sup> *Id.* (emphasis added).

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> *Id.* at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

More recently, in *Allina Health Services v. Price* (“*Allina II*”),<sup>26</sup> the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>27</sup> The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>28</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers’ Request for EJR**

The Providers explain that “[b]ecause the Secretary has not acquiesced to the decision in *Allina I*], the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The ‘2004 Rule’) The Board is bound by the 2004 Rule.”<sup>29</sup> Accordingly, the Providers contend that the Board should grant their request for EJR.

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

### **Decision of the Board**

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

### **Improper Inclusion of Previously Dismissed Providers on the Schedule of Providers**

At the outset, the Board notes that the Schedule of Providers for Case Nos. 13-3075GC, 15-0585GC, and 15-0587GC submitted by the Providers’ representative for this EJR request each *improperly* include one or more Providers that the Board has either previously dismissed or denied a transfer to a group appeal. Specifically, the Board denied the request to transfer the Medicare Managed Care Part C days issue for Lower Keys Medical Center Provider 10-0150 for FYE 9/30/2007, because the Provider did not timely appeal the issue, thus this Provider is not a part of Case No. 13-3075GC.<sup>30</sup> In addition, the Board denied the transfer requests to Case Nos. 15-0587GC and 15-0585GC for three Providers: Highlands Regional Medical Center Provider

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

<sup>28</sup> *Id.* at 943-945.

<sup>29</sup> EJR Request at 1.

<sup>30</sup> See Board correspondence regarding Case No. 13-0344 dated October 24, 2013.



10-0049 for FYE 9/30/2012,<sup>31</sup> Brooksville Regional Hospital Provider 10-0071 for 9/30/2012,<sup>32</sup> and Wuesthoff Memorial Hospital Provider 10-0092 for FYE 9/30/2012<sup>33</sup> and, thus, these three Providers are not part of Case Nos. 15-0587GC and 15-0585GC. Accordingly, the above Providers are *not currently* part of these cases and, as such, the Board can *not* consider them as part of this EJR request for these cases (notwithstanding the Provider representative's *improper* attempt to include these Providers on the relevant Schedule of Providers). The Board will address the Provider Representative's failure to comply with Board Rules under separate cover pursuant to 42 C.F.R. § 405.1868.

#### Jurisdiction for the Group Participants

The participants that *currently* comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006 through 2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").<sup>34</sup> 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.<sup>35</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>36</sup> 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*").<sup>37</sup> 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.<sup>38</sup>

<sup>31</sup> See Board correspondence regarding Case No. 14-4059 dated May 14, 2015.

<sup>32</sup> See Board correspondence regarding Case No. 14-4068 dated November 18, 2015.

<sup>33</sup> See Board correspondence regarding Case No. 14-4194 dated July 9, 2015.

<sup>34</sup> 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.).

<sup>35</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>36</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>37</sup> 201 F. Supp. 3d 131 (D.D.C. 2016)

<sup>38</sup> *Id.* at 142.

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>39</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

#### A. Jurisdictional Determination On Certain Specific Individual Participants

At the outset, the Board notes that a Board finding of jurisdiction is a prerequisite to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority to request “[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision,”<sup>40</sup> including documentation relating to jurisdiction. Similarly, the regulations governing group appeals specify that jurisdiction “may be raised at any time.”<sup>41</sup>

1. Case No. 13-2325GC: Participant 3 – Summit Medical Center, Provider No. 04-0018, FYE 12/31/2009

The Board finds that it does not have jurisdiction over Summit Medical Center because the Provider did not include a copy of its final determination in either: (a) the Schedule of Providers; or (b) its Model Form D Request to Transfer to Case No. 13-2325GC. 42 C.F.R. § 405.1835(b)(3) requires that an appeal request include a copy of the final determination being appealed. Board Rule 20 states that the Providers in a group appeal must submit a Schedule of Providers to the Board, and Board Rule 21 outlines what should be included on the Schedule as well as the supporting jurisdiction documentation that should be submitted. In particular, Board Rule 21.2.2 requires the Provider to submit the dated cover page(s) of the final determination being appealed, which Participant 3 did not do. Without this document, the Board is not able to determine if the Provider is

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<sup>39</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

<sup>40</sup> 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which included a decision on both jurisdiction and the EJR request).

<sup>41</sup> 42 C.F.R. 405.1837(e)(2) states: “*The Board may make jurisdictional findings under § 405.1840 at any time, including, but not limited to, following a request by the providers for the jurisdictional findings. The providers may request jurisdictional findings by notifying the Board in writing that the group appeal is fully formed, or that the providers believe they have satisfied all of the requirements for a group appeal hearing request, and the Board may proceed to make jurisdictional findings.*”

properly appealing from an original or revised NPR,<sup>42</sup> *and* whether the Provider's individual appeal was timely filed. Accordingly, the Board dismisses Summit Medical Center from Case No. 13-2325GC because it failed to provide the documentation necessary to demonstrate its entitlement to appeal rights under 42 C.F.R. § 1835(a)(1).

2. Case Nos. 14-1075GC and 14-1077GC: Participant 30 – Davis Regional Medical Center (“Davis”), Provider No. 34-0144, FYE 9/30/2010

In both Case Nos. 14-1075GC and 14-1077GC, Davis submitted an original Notice of Program Reimbursement that does not have either a date or evidence of receipt. 42 C.F.R. § 405.1835(a)(3) states that, “Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is *no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.*”<sup>43</sup> Without the date on the Provider's final determination (or proof of receipt), the Board is not able to determine whether the Provider timely filed its individual appeal request. Accordingly, the Board dismisses Davis Regional Medical Center from both Case Nos. 14-1075GC and 14-1077GC due to the Providers' failure to establish their entitlement to appeal rights under 42 C.F.R. § 405.1835(a)(1).

3. Case Nos. 15-0585GC and 15-0587GC: Various Providers

The Board finds that Participants 5, 8, and 9 (Chester Regional Medical Center, Physicians Regional Medical Center (St. Mary's) and Baptist Hospital of Cocke County) did not timely file appeals based on the untimely issuance of an NPR in PRRB Case Nos. 15-0585GC and 15-0587GC by their designated Medicare administrative contractor (“MAC”).

42 C.F.R. § 405.1835(a)(3)(ii) (2014) governs appeals rights originating from the failure of the MAC to timely issue an NPR, as is the case with these three Providers. It states:

If the contractor determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter), *no later than 180 days after the expiration of the 12 month period for issuance of the contractor determination.*<sup>44</sup>

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<sup>42</sup> In this regard, the Board notes that, if the Provider were appealing from a revised NPR, Board Rule 7.1.2.1 describes the additional documentation necessary to establish entitlement to appeal rights under 42 C.F.R. § 405.1835(a)(1) consistent with 42 C.F.R. § 405.1889.

<sup>43</sup> (Emphasis added.)

<sup>44</sup> (Emphasis added.)

Importantly, there is *no* five (5) day mailing presumption for appeals based on the untimely issuance of an NPR.

Provider Name and No.	FYE	Date MAC Received Cost Report	Date for Timely Filing	Date Appeal Received	# of Days
Chester Regional Medical Center (42-0019)	9/30/2012	2/27/2013	8/26/2014	8/27/2014	181
Physicians Regional Medical Center (44-0120)	9/30/2012	2/28/2013	8/27/2014	8/28/2014	181
Baptist Hospital of Cocke County (44-0153)	9/30/2012	2/28/2013	8/27/2014	8/28/2017	181

The Board finds that it does not have jurisdiction over these three Providers' appeals of the *nonissuance* of their NPR because, as shown in the above table, they did not timely appeal from the *non-issuance* of their NPRs (*i.e.*, they did not appeal the *nonissuance* within 180 days of the 12 month period for issuance of the contractor determination). Accordingly, the Board dismisses the Providers from Case Nos. 15-0585GC and 15-0587GC as it relates to their appeal from the *non-issuance* of an NPR due to the Providers' failure to establish their entitlement to appeal that *non-issuance* under 42 C.F.R. § 405.1835(a)(3)(ii) (2014).

The Board recognizes that Chester Regional Medical Center ("Chester") and Physicians Regional Medical Center ("Physicians") did later receive an NPR and that they *also* are participating in Case Nos. 15-0585GC and 15-0587GC based on appeals of the *original* NPR appeals. Accordingly, Chester and Physicians will remain pending in both Case Nos. 15-0585GC and 15-0587GC based on these *original* NPR appeals. Unlike Chester and Physicians, Baptist Hospital of Cocke County ("Baptist") did *not* file an appeal from a separate final determination (*i.e.*, original NPR) and request transfer (or direct add) into either Case Nos. 15-0585GC and 15-0587GC and, accordingly, Baptist is no longer pending in either Case Nos. 15-0585GC and 15-0587GC.

**B. Jurisdictional Determination for Remaining Participants**

With the exception of the participants described above, the Board has determined that the remaining participants' appeals involved with the instant EJR Request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R and that the participant appeals filed from a revised NPR have the appropriate adjustment to the Part C days issue within the revised NPR. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal<sup>45</sup> and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the referenced appeals and the remaining participants.

<sup>45</sup> See 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2006 through 2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPSS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPSS final rule (with a minor revision published in the FFY 2011 IPSS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>46</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>47</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

- 1) The Provider, Lower Keys 10-0150, is not part of the EJR request as it relates to Case No. 13-3075GC and Highlands Regional 10-0049, Brooksville Regional 10-0071 and Wuestoff Memorial 10-0092 are not part of the EJR request as it relates to Case Nos. 15-0585GC and 15-0587GC because the Board had previously dismissed, in pertinent part, each provider and, accordingly, from that time on, each provider was not in (and could no longer be a part of) the respective group appeal;
- 2) It also does not have jurisdiction to hear the appeals for: (a) Summit Medical Center in Case No. 13-2325GC, (b) Davis Regional Medical Center in Case Nos. 14-1075GC and 14-1077GC, and (c) Chester Regional Medical Center, Physicians Regional Medical Center, and Baptist Hospital of Cocke County in Case Nos. 15-0585GC and 15-0587GC *as it relates to the appeal for the nonissuance of an NPR under 42 C.F.R. § 405.1835(a)(3)(ii) (2014)*; and, thus, these participants as it relates to those appeals are dismissed from their respective group appeals<sup>48</sup> and from this EJR Determination;
- 3) It has jurisdiction over the matter for the subject years and that the remaining participants in these group appeals are entitled to a hearing before the Board;
- 4) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

<sup>46</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>47</sup> See 42 U.S.C. § 1395oo(f)(1).

<sup>48</sup> As previously discussed, Chester Regional Medical Center and Physicians Regional Medical Center remain pending in both Case Nos. 15-0585GC and 15 0587GC based on the appeal of their original NPR.

- 5) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 6) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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

**Board Members Participating:**

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

**For the Board:**

4/4/2019

**X** Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board  
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**Electronic Delivery**

James Ravindran President  
Quality Reimbursement Services  
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**RE: *EJR Determination***

15-2388G QRS 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days Group II  
15-3032G QRS 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group (2)  
15-3038G QRS 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days Group (2)  
16-1143G QRS 2013 DSH SSI Fraction Medicare Managed Care Part C Days Group  
16-1144G QRS 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days Group  
17-1410G QRS 2005 DSH Medicaid Fraction Medicare Managed Care Part C Days Group  
17-1411G QRS 2005 DSH SSI Fraction Medicare Managed Care Part C Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 1, 2019 request for expedited judicial review (EJR),<sup>1</sup> as well as the Providers' March 14, 2019 response to the Board's February 28, 2019 letter requesting additional information required to act upon the EJR submission. In its February 28<sup>th</sup> letter, the Board requested that the Providers clearly identify the legal authority they were challenging and how it is binding on the Board, making EJR appropriate. The Board's determination regarding both jurisdiction EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

[W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of

<sup>1</sup> This determination is one of several that will be issued in response to the four EJR requests that were filed on February 1, 2019 and March 14, 2019, involving 28 cases and approximately 680 individual Provider jurisdictional determinations. Case number 09-0993G, QRS 2006 DSH Exclusion of Part C days from the Denominator of the Medicare Percentage was included in this EJR request. The Board will respond to 09-0993G's EJR request under separate cover.

Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).<sup>2</sup>

### Statutory and Regulatory Background: Medicare DSH Payment

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>7</sup> 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.<sup>8</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>9</sup> 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 . . . .<sup>10</sup>

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<sup>2</sup> Providers' EJR request at 1.

<sup>3</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>4</sup> *Id.*

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>6</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>8</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>9</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>10</sup> (Emphasis added.)



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

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.<sup>12</sup>

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.<sup>13</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>14</sup> stated that:

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

<sup>11</sup> 42 C.F.R. § 412.106(b)(2)-(3).

<sup>12</sup> (Emphasis added.)

<sup>13</sup> 42 C.F.R. § 412.106(b)(4).

<sup>14</sup> of Health and Human Services.

Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].<sup>15</sup>

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>16</sup>

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

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

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

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

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<sup>15</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

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

<sup>18</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>19</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>20</sup> 69 Fed. Reg. at 49099.

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

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPSS final rule was issued.<sup>22</sup> In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPSS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).<sup>23</sup> As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”). Subsequently, as part of the FFY 2011 IPSS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) “to clarify” the Part C DSH policy by replacing the word “or” with “including.”<sup>24</sup>

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,<sup>25</sup> vacated both the FFY 2005 IPSS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPSS final rule codifying the Part C DSH policy

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<sup>21</sup> *Id.* (emphasis added).

<sup>22</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>23</sup> 72 Fed. Reg. at 47411.

<sup>24</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

adopted in FFY 2005 IPPS rule.<sup>26</sup> However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* (“*Allina IP*”),<sup>27</sup> the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I.*<sup>28</sup> The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>29</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers’ Request for EJR**

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

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

### **Decision of the Board**

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

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2005, 2010, 2011 and 2013.

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<sup>26</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>27</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>28</sup> *Id.* at 943.

<sup>29</sup> *Id.* at 943-945.

<sup>30</sup> Providers’ EJR Request at 1.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").<sup>31</sup> 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.<sup>32</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>33</sup> 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*").<sup>34</sup> 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.<sup>35</sup>

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

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as

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<sup>31</sup> 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.).

<sup>32</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>33</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>34</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>35</sup> *Id.* at 142.

required for a group appeal.<sup>36</sup> The appeals 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 in each case.

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2005, 2010, 2011 and 2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPSS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPSS final rule (with a minor revision published in the FFY 2011 IPSS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (e.g., only circuit-wide versus nationwide).<sup>37</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>38</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPSS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The

<sup>36</sup> See 42 C.F.R. § 405.1837.

<sup>37</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>38</sup> See 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

Clayton J. Nix, Esq.

Charlotte F. Benson, CPA

Gregory H. Ziegler, CPA, CPC-A

Robert A. Everts, Esq.

FOR THE BOARD:

4/8/2019

 Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Pam VanArsdalc, NGS(Electronic Mail w/Schedules of Providers)

Wilson Leong, (Electronic Mail w/Schedules of Providers)



**Electronic Delivery**

Stephanie Webster  
Akin Gump Strauss Hauer & Feld, LLP  
1333 New Hampshire Avenue, NW  
Washington, DC 20036-1564

**RE: *EJR Determination***

Case No. 13-0951GC – Sanford Health System 2010 SSI Part C CIRP Group

Dear Ms. Webster:

The Provider Reimbursement Review Board (“PRRB” or “Board”) has reviewed the Providers’ March 14, 2019 request for expedited judicial review (“EJR”) of the above-referenced appeal. The Board’s jurisdictional determination and decision regarding the EJR request is set forth below.

**Issue in Dispute**

The issue in this appeal is:

[W]hether “enrollees in Part C are ‘entitled to benefits’ under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction, or whether, if not regarded as ‘entitled to benefits under Part A,’ they should instead be included in the Medicaid fraction” of the DSH adjustment.<sup>1</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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

<sup>1</sup> Providers’ EJR request at 4.

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.



A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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.<sup>11</sup>

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.<sup>12</sup>

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

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<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> Emphasis added.

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At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

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

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

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

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<sup>20</sup> *Id.* (emphasis added).

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

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

### **Providers’ Request for EJR**

The Providers essentially explain that because the Secretary has not acquiesced to the decision in *Allina I*, the FY 2005 IPPS final rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (“the 2004 Rule”). As the Board is otherwise bound by the 2004 rule, the Providers contend that the Board should grant their request for EJR.

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<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> *Id.* at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs.* n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

<sup>28</sup> *Id.* at 943-945.

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

### **Decision of the Board**

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

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2010.

The Secretary updated the Board’s regulations effective August 21, 2008.<sup>29</sup> Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii). This regulation required that, 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*”).<sup>30</sup> 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.<sup>31</sup>

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R (“the Ruling”) which involves dissatisfaction with Medicare Contractor determinations for cost reporting periods ending on or after December 31, 2008, but beginning before January 1, 2016. Under the Ruling, if the Board determines that the specific item under appeal is subject to a regulation or payment policy that binds the Medicare Contractor and leaves 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) are not applicable.

<sup>29</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>30</sup> 201 F. Supp. 3d 131 (D.D.C. 2016)

<sup>31</sup> *Id.* at 142.

However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

#### Jurisdictional Determination for Participants

The Board has determined that the participants' appeals involved with the instant EJ Request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the participants have met the required amount in controversy for a hearing before the Board and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction to hear the above-captioned appeals for all group participants.

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJ requests involve the 2010 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>32</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJ, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>33</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJ request.

#### Board's Decision Regarding the EJ Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject year and that the participants in this group appeal are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

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<sup>32</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>33</sup> See 42 U.S.C. § 1395oo(f)(1).

- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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

Board Members

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

FOR THE BOARD

4/8/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: John Bloom, Noridian (Electronic Mail w/Schedules of Providers)



**Electronic Delivery**

James Ravindran  
Quality Reimbursement Services, Inc.  
150 N. Santa Anita Avenue, Suite 570A  
Arcadia, CA 91006

**RE: *EJR Determination***

- 12-0001GC, QRS Novant 2009 DSH SSI Medicare Part C Days CIRP Group
- 13-3009GC, QRS Novant 2007 DSH Medicare Managed Care Part C Days CIRP Group
- 14-0628GC, QRS Novant 2008 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Grp
- 14-0626GC, QRS Novant 2008 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP
- 14-2212GC, QRS Novant 2009 DSH SSI Fraction Medicare Managed Care Part C Days Group
- 14-2213GC, QRS Novant 2009 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP
- 15-1119GC, QRS Novant 2010 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Grp
- 15-1118GC, QRS Novant 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP
- 13-3193GC, QRS Novant 2006 DSH Medicare Managed Care Part C days Group
- 18-0273G, QRS 2007 DSH SSI Fraction Medicare Managed Care Part C Days Group
- 18-0275G, QRS 2007 DSH Medicaid Fraction Medicare Managed Care Part C Days

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“PRRB” or “Board”) has reviewed the Providers’ March 15, 2019 request for expedited judicial review (“EJR”) of the above-referenced appeals. The Board’s jurisdictional determination and decision regarding the EJR request is set forth below.

**Issue in Dispute**

The issue in these appeals is:

[W]hether “enrollees in Medicare Part C are ‘entitled to benefits’ under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction, or whether, if not regarded as ‘entitled to benefits under Part A,’ they should instead be included in the Medicaid fraction” of the DSH adjustment.<sup>1</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

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<sup>1</sup> Providers’ EJR request at 10.



prospective payment system ("PPS").<sup>2</sup> Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.<sup>3</sup>

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> Emphasis added.

<sup>10</sup> 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.<sup>11</sup>

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.<sup>12</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

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<sup>11</sup> Emphasis added.

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

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

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

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

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

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

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

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,<sup>24</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.<sup>25</sup> However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price (Allina II)*,<sup>26</sup> the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>27</sup> The D.C. Circuit further found in *Allina II* that the Secretary

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<sup>20</sup> *Id.* (emphasis added).

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> *Id.* at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs.* n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>28</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers' Request for EJR**

The Providers explain that “[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The ‘2004 Rule’) The Board is bound by the 2004 rule.”<sup>29</sup> Accordingly, the Providers contend that the Board should grant their request for EJR.

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

### **Decision of the Board**

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

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006 to 2010.

For purposes of Board jurisdiction over a participant’s appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a “self-disallowed cost,” pursuant to the Supreme Court’s reasoning set out in *Bethesda Hospital Association v. Bowen* (“*Bethesda*”).<sup>30</sup> 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

<sup>28</sup> *Id.* at 943-945.

<sup>29</sup> Providers’ EJR Request at 1.

<sup>30</sup> 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.).

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.<sup>31</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>32</sup> 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*”).<sup>33</sup> 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.<sup>34</sup>

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant’s appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>35</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

#### *Jurisdictional Determination for Participants*

The Board has determined that the participants’ appeals involved with the instant EJR Request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R and that the appeals filed from a revised NPR contain the appropriate adjustment to the Part C days issue. In addition, the participants’ documentation shows that the participants have met the required amount in controversy<sup>36</sup> for a hearing before the Board and that the appeals were timely filed.

<sup>31</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>32</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>33</sup> 201 F. Supp. 3d 131 (D.D.C. 2016)

<sup>34</sup> *Id.* at 142.

<sup>35</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

<sup>36</sup> See 42 C.F.R. § 405.1837. Although Board Rule 12.6 (August 29, 2018) states that a group appeal must contain a minimum of two different providers, for administrative efficiency sake, the group appeals within this EJR Request

The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction to hear the above-captioned appeals for all group participants.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2006 to 2010 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>37</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>38</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the participants' request for EJR for the issue. The participants have 60 days from

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that contain only one provider will be treated as individual appeals but retain the "group appeal" case number and name.

<sup>37</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>38</sup> See 42 U.S.C. § 1395oo(f)(1).

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 those cases.

Board Members Participating:

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

For the Board:

4/8/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Laurie Polson, Palmetto GBA c/o NGS (Electronic Mail w/Schedules of Providers)  
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators  
(Electronic Mail w/Schedules of Providers)





**Electronic Delivery**

James Ravindran  
Quality Reimbursement Services, Inc.  
150 N. Santa Anita Avenue, Suite 570A  
Arcadia, CA 91006

**RE: *EJR Determination***

13-3929GC, QRS BHCS 2007 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Grp  
13-3918GC, QRS BHCS 2007 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP  
13-3881GC, QRS BHCS 2008 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP  
13-3891GC, QRS BHCS 2008 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Grp  
14-2892GC, QRS BHCS 2009 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Grp  
14-2893GC, QRS BHCS 2009 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“PRRB” or “Board”) has reviewed the Providers’ March 15, 2019 request for expedited judicial review (“EJR”) of the above-referenced appeals. The Board’s jurisdictional determination and decision regarding the EJR request is set forth below.

**Issue in Dispute**

The issue in these appeals is:

[W]hether “enrollees in Medicare Part C are ‘entitled to benefits’ under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction, or whether, if not regarded as ‘entitled to benefits under Part A,’ they should instead be included in the Medicaid fraction” of the DSH adjustment.<sup>1</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

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

<sup>1</sup> Providers’ EJR request at 10.

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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.<sup>11</sup>

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(I).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> Emphasis added.

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

<sup>11</sup> Emphasis added.

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

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

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<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

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

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

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

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

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

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

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.<sup>20</sup>

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.<sup>21</sup> In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).<sup>22</sup> As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”).<sup>23</sup>

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

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<sup>20</sup> *Id.* (emphasis added).

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> *Id.* at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs.* n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

<sup>28</sup> *Id.* at 943-945.

### Providers' Request for EJR

The Providers explain that “[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R.

§§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The 2004 Rule) The Board is bound by the 2004 rule.”<sup>29</sup> Accordingly, the Providers contend that the Board should grant their request for EJR.

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

### Decision of the Board

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

### Jurisdiction

The participants that comprise the above-captioned group appeals within this EJR request have filed appeals involving fiscal years 2007 to 2009.

For purposes of Board jurisdiction over a participant’s appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a “self-disallowed cost,” pursuant to the Supreme Court’s reasoning set out in *Bethesda Hospital Association v. Bowen* (“*Bethesda*”).<sup>30</sup> 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

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<sup>29</sup> Providers’ EJR Request at 1.

<sup>30</sup> 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.<sup>31</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>32</sup> 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*”).<sup>33</sup> 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.<sup>34</sup>

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant’s appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>35</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

#### Jurisdictional Determination for Individual Participants

1. *Case Nos. 13-3929GC and 13-3918GC—Participant 1, Baylor Medical Center at Irving (“Baylor-Irving”), Prov. No. 45-0079, FYE June 30, 2007*

Baylor-Irving filed a July 27, 2016 individual appeal request with the Board based upon the Baylor-Irving’s January 26, 2016 revised NPR. Upon review of Baylor-Irving’s revised NPR, the Board finds that Baylor-Irving failed to document that the Medicare contractor adjusted the matter under appeal in these EJR requests, namely the Part C

<sup>31</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>32</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>33</sup> 201 F. Supp. 3d 131 (D.D.C. 2016)

<sup>34</sup> *Id.* at 142.

<sup>35</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

Days, in either the SSI percentage/Medicare Fraction or the Medicaid Fraction. 42 C.F.R. § 405.1889(b)(1)-(2) (2015) governs appeals of revised determinations and specifies that “[o]nly those matters that are *specifically revised* in a revised determination . . . are within the scope of any appeal of the revised determination [and] [a]ny matter that is not specifically revised . . . may not be considered in any appeal of the revised determination . . .”<sup>36</sup> As such, under the pertinent Board jurisdiction regulations, Baylor-Irving’s revised NPR appeal included within this group is not within the jurisdiction of the Board and must be dismissed from the appeal and denied EJR.

2. *Case Nos. 13-3929GC and 13-3918GC—Participant 3, Baylor Medical Center-Garland (“Baylor-Garland”), Prov. No. 45-0280, FYE December 31, 2007*

Baylor-Garland filed a December 23, 2015 individual appeal request with the Board based upon Baylor-Garland’s June 26, 2015 revised NPR. Upon review of Baylor-Garland’s revised NPR, the Board finds that Baylor-Garland failed to document that the Medicare contractor adjusted the matter under appeal in these EJR requests, namely the Part C Days in either the SSI percentage/Medicare Fraction or the Medicaid Fraction. 42 C.F.R. § 405.1889(b)(1)-(2) (2015) governs appeals of revised determinations and specifies that “[o]nly those matters that are *specifically revised* in a revised determination . . . are within the scope of any appeal of the revised determination [and] [a]ny matter that is not specifically revised . . . may not be considered in any appeal of the revised determination . . .”<sup>37</sup> As such, under the pertinent Board jurisdiction regulations, Baylor-Garland’s revised NPR appeal included within this group is not within the jurisdiction of the Board and must be dismissed from the appeal and denied EJR.

Jurisdictional Determination for Remaining Participants

With the exception of the two participants described above, the Board has determined that the remaining participants’ appeals involved with the instant EJR Request for the above-captioned group cases are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R and that the participant appeals filed from a revised NPR have the appropriate adjustment to the Part C days issue within the revised NPR. In addition, the participants’ documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal<sup>38</sup> and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the above-captioned appeals and the remaining participants.

Board’s Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2007 to 2009 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary’s Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and

<sup>36</sup> (Emphasis added.)

<sup>37</sup> (Emphasis added.)

<sup>38</sup> See 42 C.F.R. § 405.1837.



later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>39</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>40</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

*Board's Decision Regarding the EJR Request*

The Board finds that:

- 1) It does not have jurisdiction to hear the revised NPR appeals for Baylor Medical Center at Irving, Provider No. 45-0079, and Baylor Medical Center-Garland, Provider No. 45-0280 in connection with Case Nos. 13-3929GC and 13-3918GC, as explained above and accordingly, thus these participants revised NPR appeals are dismissed from Case Nos. 13-3929GC and 13-3918GC and from this EJR Determination;
- 2) It has jurisdiction over the matter for the subject years and that the remaining participants in these group appeals are entitled to a hearing before the Board;
- 3) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 4) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 5) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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

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<sup>39</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>40</sup> See 42 U.S.C. § 1395oo(f)(1).

Board Members Participating:

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

FOR THE BOARD:

4/8/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton, J. Nix -A

Enclosures: Schedules of Providers

cc: Bill Tisdale, Novitas Solutions, Inc. (Electronic Mail w/Schedules of Providers)  
Bruce Snyder, Novitas Solutions, Inc. (Electronic Mail w/Schedules of Providers)



**Electronic Delivery**

Delbert Nord  
Quality Reimbursement Services, Inc.  
112 N. University Road  
Suite 308  
Spokane Valley, WA 99206

RE: ***Expedited Judicial Review Determination for PRRB Case Numbers:***  
09-2107GC QRS Multicare 2006 Medicare Part C Days CIRP Group  
15-1793GC QRS Multicare 2010 Medicaid Fraction Part C Days CIRP Group  
15-1802GC QRS Multicare 2011 Medicaid Fraction Part C Days CIRP Group

Dear Mr. Nord:

The Provider Reimbursement Review Board (“PRRB” or “Board”) has reviewed the Providers’ March 20, 2019 request for expedited judicial review (“EJR”) of the above referenced appeals. The Board’s jurisdictional determination and decision regarding the EJR request is set forth below.

**Issue in Dispute**

The issue in these appeals is:

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

**Statutory and Regulatory Background: Medicare DSH Payment**

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

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.<sup>4</sup> These cases involve the hospital-specific DSH adjustment, which requires the

<sup>1</sup> Providers’ EJR request at 1.

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.<sup>5</sup>

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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.<sup>11</sup>

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> Emphasis added.

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

<sup>11</sup> Emphasis added.

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

### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

With the creation of Medicare Part C in 1997,<sup>16</sup> Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

<sup>16</sup> The Medicare Part C program did not begin operating until January 1, 1999. See P.L. 105-33, 1997 HR 2015, codified as 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.<sup>17</sup>

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

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

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

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

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

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

<sup>20</sup> *Id.* (emphasis added).

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

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

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

### **Providers’ Request for EJRB**

The Providers explain that “[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> *Id.* at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPSS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

<sup>28</sup> *Id.* at 943-945.

from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The '2004 Rule') The Board is bound by the 2004 Rule."<sup>29</sup> Accordingly, the Providers contend that the Board should grant their request for EJR.

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

### **Decision of the Board**

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

### **Jurisdiction for the Group Participants**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006, 2010 and 2011.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").<sup>30</sup> 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.<sup>31</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>32</sup> 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-

<sup>29</sup> EJR Request at 1.

<sup>30</sup> 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.).

<sup>31</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>32</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).



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*”).<sup>33</sup> 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 EJER 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.<sup>34</sup>

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

#### A. Jurisdictional Determination On Specific Individual Participant

At the outset, the Board notes that a Board finding of jurisdiction is a prerequisite to any review of an EJER request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority request “[a]ll of the information and documents found necessary by the Board for issuing a[n EJER] decision,”<sup>35</sup> including documentation relating to jurisdiction. Similarly, the regulations governing group appeals specify that jurisdiction “may be raised at any time.”<sup>36</sup>

1. Case No. 09-2107GC: Participant 3 – Good Samaritan Hospital, Provider No. 50-T079, FYE 12/31/2007

The Board finds that it does not have jurisdiction over Participant 3, the Inpatient Rehabilitation Facility (“IRF”) subunit of Good Samaritan Hospital, because Congress has prohibited administrative and judicial review of prospective payment rates for IRFs.

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

<sup>33</sup> 201 F. Supp. 3d 131 (D.D.C. 2016)

<sup>34</sup> *Id.* at 142.

<sup>35</sup> 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which included a decision on both jurisdiction and the EJER request).

<sup>36</sup> 42 C.F.R. 405.1837(e)(2) states: “*The Board may make jurisdictional findings under § 405.1840 at any time, including, but not limited to, following a request by the providers for the jurisdictional findings. The providers may request jurisdictional findings by notifying the Board in writing that the group appeal is fully formed, or that the providers believe they have satisfied all of the requirements for a group appeal hearing request, and the Board may proceed to make jurisdictional findings.*”

facilities (“IRFs”). Although providers have attempted to dispute exactly what rate-setting “steps” Congress intended to shield from review under the statute, the U.S. Court of Appeals, District of Columbia Circuit’s decision in *Mercy Hospital, Inc. v. Azar* (“*Mercy*”), answers this question and clarifies what is shielded from review in its analysis of this issue.<sup>37</sup>

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.” 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 U.S. 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.<sup>38</sup> 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.<sup>39</sup>

In the instant appeal, the Provider seeks Board review of one of the components utilized by the Medicare Contractor to determine the Provider’s LIP adjustment, namely Medicare Managed Care Part C Days. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board finds that it lacks the jurisdiction to hear the Provider’s appeal of the LIP adjustment and dismisses the issue in the instant appeal that challenges this adjustment. In making this finding, the Board notes that the D.C. Circuit decision in *Mercy* is controlling precedent because the Provider could bring suit in the D.C. Circuit.<sup>40</sup>

<sup>37</sup> *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).

<sup>38</sup> *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at \*8 (D.D.C. July 25, 2016).

<sup>39</sup> *Mercy*, 891 F.3d at 1068.

<sup>40</sup> The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. See, e.g., *QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass’n*, Adm’r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass’n*, Adm’r Dec. (Nov. 17, 2008), affirming in part and reversing in part, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. See, e.g., *Jordan Hosp. v. Blue Cross Blue Shield Ass’n*, Adm’r Dec. (Apr. 30, 2007), vacating, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

B. Jurisdictional Determination for Remaining Participants

With the exception of Good Samaritan Hospital, Provider No. 50-T079, discussed above, the Board has determined that the remaining participants' appeals involved with the instant EJR Request for Case Nos. 09-2107GC, 15-1793GC and 15-1802GC are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R and that the participant appeals filed from a revised NPR have the appropriate adjustment to the Part C days issue within the revised NPR. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal<sup>41</sup> and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the referenced appeals and the remaining participants.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2006, 2010 and 2011 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPSS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPSS final rule (with a minor revision published in the FFY 2011 IPSS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (e.g., only circuit-wide versus nationwide).<sup>42</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit or the circuit within which they are located.<sup>43</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It does not have jurisdiction to hear the appeal for Good Samaritan Hospital (provider number 50-T079, FYE 12/31/2007) in Case No. 09-2107GC, thus this Provider is dismissed from the appeal and from this EJR Determination;
- 2) It has jurisdiction over the matter for the subject years and that the remaining participants in these group appeals are entitled to a hearing before the Board;

<sup>41</sup> See 42 C.F.R. § 405.1837.

<sup>42</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>43</sup> See 42 U.S.C. § 1395oo(f)(1).

- 3) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 4) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 5) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPSS final rule are valid.

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

**Board Members Participating:**

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

**For the Board:**

4/8/2019

**X** Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: John Bloom, Noridian Healthcare Solutions



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board  
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**Electronic Delivery**

James Ravindran, President  
Quality Reimbursement Services  
150 N. Santa Anita Avenue  
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**RE: *EJR Determination***

- 13-3928G QRS 2009 DSH SSI Fraction/Medicare Managed Care Part C Days Group
- 13-3941G QRS 2009 DSH Medicaid Fraction/Medicare Managed Care Part C Days
- 14-1167G QRS 2008 DSH SSI Fraction Medicare Managed Care Part C Days Group
- 14-1820G QRS 2010 DSH SSI Fraction Medicare Managed Care Pt. C Days Group
- 14-1822G QRS 2010 DSH Medicaid Fraction Medicare Managed Care Pt. C Days
- 14-3297G QRS 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group
- 17-1424G QRS 2006 DSH SSI Fraction Medicare Managed Care Part C Days Group 3
- 17-1425G QRS 2006 DSH Medicaid Fraction Medicare Managed Care Part C

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ February 1, 2019 request for expedited judicial review (“EJR”),<sup>1</sup> as well as the Providers’ March 14, 2019 response to the Board’s February 28, 2019 letter requesting additional information required to act upon the EJR submission. In its February 28<sup>th</sup> letter, the Board requested that Providers clearly identify the legal authority they were challenging and how it is binding on the Board, making EJR appropriate. The Board’s determination regarding both jurisdiction and EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

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<sup>1</sup> This determination is one of several that will be issued in response to the four EJR requests that were filed on February 1, 2019 and March 14, 2019, involving 28 cases and approximately 680 individual Provider jurisdictional determinations.

[W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.<sup>2</sup>

### Statutory and Regulatory Background: Medicare DSH Payment

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>7</sup> 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.<sup>8</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>9</sup> 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 . . . .<sup>10</sup>

<sup>2</sup> Providers' EJR request at 1.

<sup>3</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>4</sup> *Id.*

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>6</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>8</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>9</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>10</sup> (Emphasis added.)

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

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.<sup>12</sup>

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.<sup>13</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>14</sup> stated that:

Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated

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<sup>11</sup> 42 C.F.R. § 412.106(b)(2)-(3).

<sup>12</sup> (Emphasis added.)

<sup>13</sup> 42 C.F.R. § 412.106(b)(4).

<sup>14</sup> of Health and Human Services.

with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].<sup>15</sup>

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>16</sup>

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

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

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

<sup>15</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>16</sup> *Id.*

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

<sup>18</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>19</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).



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

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

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.<sup>22</sup> In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).<sup>23</sup> As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) “to clarify” the Part C DSH policy by replacing the word “or” with “including.”<sup>24</sup>

<sup>20</sup> 69 Fed. Reg. at 49099.

<sup>21</sup> *Id.* (emphasis added).

<sup>22</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>23</sup> 72 Fed. Reg. at 47411.

<sup>24</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),<sup>25</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.<sup>26</sup> However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina IP*"),<sup>27</sup> the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>28</sup> The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>29</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers' Request for EJR**

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

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

### **Decision of the Board**

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

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§ 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>26</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

<sup>27</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>28</sup> *Id.* at 943.

<sup>29</sup> *Id.* at 943-945.

<sup>30</sup> Providers' EJR Request at 1.

challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

*Improper* Inclusion of Previously Dismissed Provider on the Schedule of Providers

At the outset, the Board notes that the Schedules of Providers submitted by the Provider Representative with the EJR requests for Case Nos. 13-3928G and 13-3941G each *improperly* include Rapid City Regional Hospital (Provider No. 43-0077) that the Board previously has issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeals. Accordingly, this Provider is not part of Case Nos. 13-3928G and 13-3941G and, as such, cannot be considered in this EJR request. The Board will address the Provider Representative's failure to comply with Board Rules under separate cover pursuant to 42 C.F.R. § 405.1868.

Jurisdiction Over Participants *Currently* in the Above-Captioned Group Appeals

The participants that *currently* comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006, 2008, 2009, 2010 and 2011.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").<sup>31</sup> 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.<sup>32</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>33</sup> 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*").<sup>34</sup> 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

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<sup>31</sup> 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.).

<sup>32</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>33</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>34</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

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.<sup>35</sup>

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

1. *Case No. 13-3941G—Participant # 55 Harrison Medical Center (Provider No. 50-0039)*

On May 21, 2018, the Board granted the Provider's request to transfer from Case No. 12-0281G to Case No. 13-3941G. In granting this request, the Board further instructed the Group Representative (QRS) to file an updated Schedule of Providers and supplemental jurisdictional documents within 30 days of the date of the May 21<sup>st</sup> letter since the Schedule of Providers and jurisdictional documentation had already been filed in Case No. 13-3941G. Notwithstanding this instruction, there is no supplemental information for Harrison Medical in the record. Accordingly, the Board hereby dismisses Harrison Medical Center from Case No. 13-3941G because the Provider failed to comply with the Board's instructions and has not demonstrated that it has a jurisdictional proper appeal of the Part C days issue pending before the Board as required by 42 C.F.R. §§ 405.1835-405.1837. Since establishing jurisdiction over a provider is a prerequisite to granting the request for EJR, the Provider's request for EJR as it relates to Case No. 13-3941G is denied.<sup>36</sup>

2. *Remaining Participants in the Above-Captioned Group Cases*

The Board has determined that the remaining participants involved with the instant EJR request for the above-captioned group cases are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>37</sup> The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying remaining providers. The estimated

<sup>35</sup> *Id.* at 142.

<sup>36</sup> See 42 C.F.R. § 405.1842(a).

<sup>37</sup> See 42 C.F.R. § 405.1837.

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

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2006, 2008, 2009, 2010 and 2011 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPSS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPSS final rule (with a minor revision published in the FFY 2011 IPSS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (e.g., only circuit-wide versus nationwide).<sup>38</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>39</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the remaining participants in these group appeals (as delineated in the attached schedules) are entitled to a hearing before the Board;
- 2) Based upon the remaining participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPSS final rule are valid.

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<sup>38</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>39</sup> See 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

Clayton J. Nix, Esq.


Charlotte F. Benson, CPA

Gregory H. Ziegler, CPA, CPC-A

Robert A. Everts, Esq.

FOR THE BOARD:

4/8/2019

 Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: John Bloom, Noridian (Electronic Mail w/Schedules of Providers)  
Bruce Synder, Novitas (Electronic Mail w/Schedules of Providers)  
Wilson Leong, (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

Isaac Blumberg  
Blumberg Ribner, Inc.  
315 South Beverly Drive  
Suite 505  
Beverly Hills, CA 90212-1925

**RE: *EJR Determination***

18-0415G BRI Independent Hospitals 2007 Medicare HMO Part C Fraction Group  
18-0416G BRI Independent Hospitals 2007 Medicaid HMO Part C Fraction Group  
18-0577G BRI Independent Hospitals 2009 Medicare HMO Part C Fraction Group  
18-0578G BRI Independent Hospitals 2009 Medicaid HMO Part C Fraction Group

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 26, 2019 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

Whether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).<sup>1</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

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<sup>1</sup> Providers' EJR request at 1.

prospective payment system ("PPS").<sup>2</sup> Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.<sup>3</sup>

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> (Emphasis added.)

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).



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.<sup>11</sup>

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.<sup>12</sup>

### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

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<sup>11</sup> (Emphasis added.)

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

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

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

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

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

... We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are

<sup>15</sup> *Id.*

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

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

*not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*<sup>20</sup>

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),<sup>24</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.<sup>25</sup> However, the Secretary has not acquiesced to that decision.

<sup>20</sup> *Id.* (emphasis added).

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> 72 Fed. Reg. at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

More recently, in *Allina Health Services v. Price* (“*Allina I*”),<sup>26</sup> the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>27</sup> The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>28</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers’ Request for EJR**

The Providers assert that EJR is appropriate because the Secretary has not acquiesced to the decision in *Allina I*. As a result, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). The Providers point out that they have met the timely filing requirements and the amount in controversy and believe that EJR is appropriate since the Board is bound by the regulation.

### **Decision of the Board**

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

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2007 and 2009.

For purposes of Board jurisdiction over a participant’s appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a “self-disallowed cost,” pursuant to the Supreme Court’s reasoning set out in *Bethesda Hospital Association v. Bowen* (“*Bethesda*”).<sup>29</sup> 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

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<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

<sup>28</sup> *Id.* at 943-945.

<sup>29</sup> 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.).

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.<sup>30</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>31</sup> 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*”).<sup>32</sup> 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.<sup>33</sup>

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant’s appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>34</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the participants involved with the instant EJR request is governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. In addition, the participants’ documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>35</sup> The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The appeals from revised NPRs have adjustments to the Part C issue as required for jurisdiction over the appeal.

<sup>30</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>31</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>32</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>33</sup> *Id.* at 142.

<sup>34</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

<sup>35</sup> See 42 C.F.R. § 405.1837.

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

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2007 and 2009 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>36</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>37</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The

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<sup>36</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>37</sup> See 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

Clayton J. Nix, Esq.

Charlotte F. Benson, CPA

Gregory H. Ziegler, CPA, CPC-A

Robert A. Everts, Esq.

Susan A. Turner, Esq.

FOR THE BOARD:

4/10/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Pam VanArsdale, NGS (Electronic Mail w/Schedules of Providers)

Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

Michael G. Newell  
Southwest Consulting Associates  
2805 Dallas Parkway  
Suite 620  
Plano, TX 75093-8724

**RE: *EJR Determination***

15-1755GC SWC Covenant Health 2012 DSH SSI Fraction Part C Days Group  
15-1756GC SWC Covenant Health 2012 DSH Medicaid Fraction Part C Days Group

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 26, 2019 request for expedited judicial review ("EJR") (received March 29, 2019) for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

[W]hether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator or vice-versa.<sup>1</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

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

<sup>1</sup> Providers' EJR Request at 4.

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*



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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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.<sup>11</sup>

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<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> (Emphasis added.)

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

<sup>11</sup> (Emphasis added.)

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

### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

With the creation of Medicare Part C in 1997,<sup>16</sup> Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

<sup>16</sup> The Medicare Part C program did not begin operating until January 1, 1999. See P.L. 105-33, 1997 HIR 2015, codified as 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.<sup>17</sup>

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

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

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

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

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

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

associated with M+C beneficiaries in the Medicare fraction  
of the DSH calculation.<sup>20</sup>

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

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

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

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<sup>20</sup> *Id.* (emphasis added).

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> 72 Fed. Reg. at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

<sup>28</sup> *Id.* at 943-945.

### **Providers' Request for EJR**

The issue under appeal in this case involves the question of whether Medicare Part C patients are "entitled to benefits" under Part A, thereby requiring them to be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator or vice versa.

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.<sup>29</sup>

In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."<sup>30</sup> The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the 2004 rule that the Board lacks the authority to grant. The Providers maintain that, since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

### **Decision of the Board**

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

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 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 SSI/Part C issue as a "self-

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<sup>29</sup> 69 Fed. Reg. at 49,099.

<sup>30</sup> *Allina* at 1109.

disallowed cost,” pursuant to the Supreme Court’s reasoning set out in *Bethesda Hospital Association v. Bowen* (“*Bethesda*”).<sup>31</sup> 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.<sup>32</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>33</sup> 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*”).<sup>34</sup> 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.<sup>35</sup>

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant’s appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>36</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

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<sup>31</sup> 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.)

<sup>32</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>33</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>34</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>35</sup> *Id.* at 142.

<sup>36</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

The Board has determined that the participants involved with the instant EJR request is governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>37</sup> The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The appeals from revised NPRs have adjustments to the Part C issue as required for jurisdiction over the appeal. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involves the cost 2012 reporting period. Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPSS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPSS final rule (with a minor revision published in the FFY 2011 IPSS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>38</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>39</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject year and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPSS final rule are valid.

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<sup>37</sup> See 42 C.F.R. § 405.1837.

<sup>38</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>39</sup> See 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

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

FOR THE BOARD:

4/10/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Cecile Huggins, Cahaba GBA (Electronic Mail w/Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)





DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board  
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**Electronic Delivery**

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

**RE: *EJR Determination***

- 14-1173G QRS 2007 DSH SSI Fraction Medicare Managed Care Part C Days Group
- 14-3881G QRS 2008 DSH Medicaid Fraction/Medicare Managed Care Part C Days CIRP Grp (2)
- 15-0020G QRS 2012 DSH Medicaid Fraction/Medicare Managed Care Part C Days Group
- 15-1140G QRS 2006 DSH Medicaid Fraction Medicare Managed Care Part C Days Group (2)
- 15-1144G QRS 2006 DSH SSI Fraction Medicare Managed Care Part C Days Group (2)
- 15-1423G QRS 2012 DSH SSI Fraction Medicare Managed Care Part C Days Group
- 15-2387G QRS 2010 DSH SSI Fraction Medicare Managed Care Pt. C Days Group II

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ February 1, 2019 request for expedited judicial review (“EJR”), as well as the Providers’ March 14, 2019 response to the Board’s February 28, 2019 letter requesting additional information required to act upon the EJR submission. In its February 28<sup>th</sup> letter, the Board requested that Providers clearly identify the legal authority they were challenging and how it is binding on the Board, making EJR appropriate. The Board’s determination regarding both jurisdiction and EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

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

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<sup>1</sup> Providers’ EJR request at 1.

### **Statutory and Regulatory Background: Medicare DSH Payment**

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> (Emphasis added.)

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

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

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

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.<sup>12</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

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<sup>11</sup> (Emphasis added.)

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].<sup>14</sup>

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

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

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

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

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

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

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation.”<sup>19</sup> In response to a comment regarding this change, the Secretary explained that:

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

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

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

<sup>19</sup> 69 Fed. Reg. at 49099.

<sup>20</sup> *Id.* (emphasis added).

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> 72 Fed. Reg. at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and

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

### **Providers' Request for EJR**

The Providers explain that "[b]ecause the Secretary has not acquiesced to the decision in *Allina II*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The '2004 Rule') The Board is bound by the 2004 rule."<sup>29</sup> Accordingly, the Providers contend that the Board should grant their request for EJR.

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

### **Decision of the Board**

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2017), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a

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§ 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

<sup>28</sup> *Id.* at 943-945.

<sup>29</sup> Providers' EJR Request at 1.

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.

*Improper* Inclusion of Previously Dismissed Providers on the Schedule of Providers

At the outset, the Board notes that the Schedule of Providers submitted by the Provider Representative with the EJR request for Case Nos. 15-0020G and 15-1423G *improperly* includes Lawrence & Memorial Hospital (Provider No. 07-0007, FYE 9/30/2012) that the Board previously has issued a determination dated November 7, 2016 (as modified by letter dated December 12, 2016) denying jurisdiction over the Provider and its request to transfer to Case Nos. 15-0020G and 15-1423G. Accordingly, notwithstanding the Provider Representative's *improper* attempt to include the Provider on the Schedule of Providers, this Provider is *not currently* part of Case Nos. 15-0020G and 15-1423G and, as such, cannot be considered in this EJR request as it relates to Case Nos. 15-0020G and 15-1423G. The Board will address the Provider Representative's failure to comply with Board Rules under separate cover pursuant to 42 C.F.R. § 405.1868.

Jurisdiction for the Participants *Currently* in the Above-Captioned Group Appeals

The participants that *currently* comprise the above-captioned group appeals within this EJR request have filed appeals involving fiscal years 2006, 2007, 2008, 2010 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 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*").<sup>30</sup> 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.<sup>31</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>32</sup> 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-

<sup>30</sup> 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.).

<sup>31</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>32</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

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*”).<sup>33</sup> 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.<sup>34</sup>

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

#### *A. Jurisdictional Determination for Certain Individual Providers*

At the outset, the Board notes that a Board finding of jurisdiction is a prerequisite to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority request “[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision,” including documentation relating to jurisdiction. Similarly, the regulations governing group appeals specify that jurisdiction “may be raised at any time.” To this end, Board Rule 20 requires the group representative to the Schedule of Providers and supporting jurisdiction documentation for a group case within 60 days of the full formation of the group and the requisite jurisdiction documentation for each provider in the Schedule of Providers is organized by Tabs A through H.

##### 1. Case No. 14-1173G—#28 Union General Hospital (Provider No. 11-0051)

42 C.F.R. § 405.1881 allows a provider to appoint a representative for Board proceedings. Consistent with this regulation, Board Rules 5.1 and 5.4 require that when a provider appoints a representative that the provider or that representative file a letter of representation from the provider confirming that appointment. The record does not contain a letter of representation confirming that the Group Representative has been appointed by this Provider to represent it. Specifically, there is *no* letter of representation

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<sup>33</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>34</sup> *Id.* at 142.



under Tab H as required by Board Rules 5.1, 5.4, and 21.9.2 *and* the Provider failed to sign the transfer to group letter. Further, the Board notes that QRS included the original appeal in the Schedule of Providers but it did not include a letter of representation. Accordingly, the Board hereby dismisses the Union General Hospital from the appeal for failing to submit a letter of representation letter as required by Board Rules 5.1, 5.4, and 21.9.2. Since the Provider is not a participant in Case No. 14-1173G, the Provider's request for EJR as it relates to Case No. 14-1173G is denied.

2. Case No. 14-1173G—#48 Yakima Valley Memorial Hospital (Provider No. 50-0036)

The individual appeal for Yakima Valley Memorial Hospital ("Yakima") was filed by Bennett and Bigelow and assigned Case No. 13-3177. On December 27, 2013, the Board bifurcated QRS' SSI group appeal, Case No. 13-2679G and created Case No. 14-1173G. *Subsequent to this bifurcation* (as well as the initial schedule filed for these groups), Yakima requested to transfer to only Case No. 13-2679G on February 23, 2014 and did not separately request to transfer to Case No. 14-1173G. As a result, Yakima is *not* part of Case No. 14-1173G. Accordingly, the Board hereby dismisses Yakima from Case No. 14-1173G because there is no evidence that the Provider transferred the Part C issue into Case No. 14-1173G. Similarly, the Provider's request for EJR as it relates to Case No. 14-1173G is denied.

*B. Jurisdiction for the Remaining Providers in the Above-Captioned Group Appeals (i.e., with exception of the previously dismissed participants and the participants dismissed above)*

The Board has determined that the remaining participants involved with the instant EJR request for the above-captioned group appeals are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>35</sup> The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying remaining providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2006, 2007, 2008, 2010 and 2012 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that

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<sup>35</sup> See 42 C.F.R. § 405.1837.

*vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>36</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>37</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the remaining participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the remaining participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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

#### Board Members Participating:

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

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<sup>36</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>37</sup> See 42 U.S.C. § 1395oo(f)(1).

FOR THE BOARD:

4/11/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Pam VanArsdale, NGs (Electronic Mail w/Schedules of Providers)  
Geoff Pike, First Coast Service Options (*Electronic Mail w/Schedules of Providers*)  
Wilson Leong, (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board  
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**Electronic Delivery**

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

**RE: *Expedited Judicial Review Determination***  
09-0993G QRS 2006 DSH Exclusion of Part C Days from the Denominator of the  
Medicare Fraction Percentage

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 1, 2019 request for expedited judicial review ("EJR"),<sup>1</sup> as well as the Providers' March 14, 2019 response to the Board's February 28, 2019 letter requesting additional information required to act upon the EJR submission. In its February 28th letter, the Board requested that the Providers clearly identify the legal authority they were challenging and how it is binding on the Board, making EJR appropriate. The Board's determination regarding both jurisdiction and EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

[W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).<sup>2</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

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<sup>1</sup> This determination is one of several that will be issued in response to the four EJR requests that were filed on February 1, 2019 and March 14, 2019, involving 28 cases and approximately 680 individual Provider jurisdictional determinations.

<sup>2</sup> Providers' EJR request at 1.

prospective payment system ("PPS").<sup>3</sup> Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.<sup>4</sup>

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>7</sup> 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.<sup>8</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>9</sup> 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.<sup>10</sup>

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.<sup>11</sup>

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

<sup>3</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>4</sup> *Id.*

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>6</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>8</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>9</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>10</sup> (Emphasis added.)

<sup>11</sup> 42 C.F.R. § 412.106(b)(2)-(3).

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

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.<sup>13</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>14</sup> stated that:

Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment].

However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].<sup>15</sup>

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>16</sup>

With the creation of Medicare Part C in 1997,<sup>17</sup> Medicare beneficiaries who opted for managed

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<sup>12</sup> (Emphasis added.)

<sup>13</sup> 42 C.F.R. § 412.106(b)(4).

<sup>14</sup> Secretary of Health and Human Services.

<sup>15</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>16</sup> *Id.*

<sup>17</sup> The Medicare Part C program did not begin operating until January 1, 1999. See P.L. 105-33, 1997 HR 2015,

care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.<sup>18</sup>

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

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

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

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

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codified as 42 U.S.C. § 1394w-21 Note (c) “Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . .” This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

<sup>18</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>19</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>20</sup> 69 Fed. Reg. at 49099.

days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.<sup>21</sup>

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.<sup>22</sup> In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 12.106(b)(2)(i)(B) and (b)(2)(iii)(B).<sup>23</sup> As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) “to clarify” the Part C DSH policy by replacing the word “or” with “including.”<sup>24</sup>

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),<sup>25</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.<sup>26</sup> However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* (“*Allina II*”),<sup>27</sup> the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>28</sup> The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>29</sup> Once again, the Secretary has not acquiesced to this decision.

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<sup>21</sup> *Id.* (emphasis added).

<sup>22</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>23</sup> 72 Fed. Reg. at 47411.

<sup>24</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>26</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>27</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>28</sup> *Id.* at 943.

<sup>29</sup> *Id.* at 943-945.



### **Providers' Request for EJR**

The Providers contend that “[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C Days to be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 405.106(b)(2)(I)(B) and (b)(2)(iii)(B). (The ‘2004 Rule’) The Board is bound by the 2004 Rule.”<sup>30</sup> The Providers contend that the pre-2004 version of the DSH regulation should remain in place, providing that the numerator of the DSH fraction include only “covered patient days that . . . are furnished to patients who, during that month were entitled to both Medicare Part A and SSI.”<sup>31</sup>

The Providers believe that the Board is without the authority to grant the relief they are seeking: an order that Part C Days should be excluded from the Part A/SSI fraction and included in the numerator of the Medicaid fraction. Consequently, they contend EJR is appropriate.

### **Decision of the Board**

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

### **Jurisdiction for the Group Participants**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2006.

For purposes of Board jurisdiction over a participant’s appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a “self-disallowed cost,” pursuant to the Supreme Court’s reasoning set out in *Bethesda Hospital Association v. Bowen* (“*Bethesda*”).<sup>32</sup> 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.<sup>33</sup> However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

<sup>30</sup> Providers’ Revised EJR Request at 1.

<sup>31</sup> 42 C.F.R. § 412.106(b)(2)(i)(2003).

<sup>32</sup> 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.).

<sup>33</sup> *Bethesda*, 108 S. Ct. at 1258-59.

A. Jurisdictional Determination On Certain Specific Individual Participants

At the outset, the Board notes that a Board finding of jurisdiction is a prerequisite to any review of an EJР request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority request “[a]ll of the information and documents found necessary by the Board for issuing a[n EJР] decision,” including documentation relating to jurisdiction. Similarly, the regulations governing group appeals specify that jurisdiction “may be raised at any time.” To this end, Board Rule 20 (2018) requires the group representative to the Schedule of Providers and supporting jurisdiction documentation for a group case within 60 days of the full formation of the group and the requisite jurisdiction documentation for each provider in the Schedule of Providers is organized by Tabs A through H.

# 3 Naples Community Hospital (Provider No. 10-0018)

The supporting jurisdiction documentation filed by the Group Representative for Naples Community Hospital (“Naples”) at Tab B confirms that Naples filed its individual appeal using Model Form A, Request for Individual Appeal. However, the documentation under Tab B for Naples did not include the statement of issues appealed that would have been attached to this Model Form A and, as a result, there is no proof that Naples appealed the Part C Days issue to then be able to transfer that issue to the current group appeal. Similarly, the Model Form D (transfer) for Naples at Tab G does not include a list of issues. 42 C.F.R. § 405.1835(b)(2008) requires that the appeal include an explanation of the provider’s dissatisfaction for each specific item at issue, why the Medicare payment is incorrect, and both how and why the payment must be determined differently. In this regard, Board Rule 7 (2008) required a statement of issues be included with the original hearing request and Rule 21.B requires that the original hearing request and the statement of the issue be included under Tab B. As Naples failed to document that it properly appealed the Part C Days issue, the Board dismisses Naples from the group appeal for lack of jurisdiction pursuant to 42 C.F.R. § 405.1840(b). Since Naples is not a participant in Case No. 09-0993G, Naples’ request for EJР as it relates to Case No. 09-0993G is denied.

# 5 Monogahela Valley Hospital (Provider No. 39-0147)

For Monogahela Valley Hospital (“Monogahela”), the Provider Representative included a copy of the original individual hearing request (a letter, not Model Form A) at Tab B. This hearing request included two issues: (1) the Intermediary’s alleged failure to include as Medicaid-eligible days services to patients eligible for Medicaid, as well as patients eligible for general assistance; and (2) Monogahela’s disproportionate share adjustment was not correctly calculated because the Intermediary did not furnish the matching data from the SSI proxy and the information is not available to Monogahela because is protected by the Privacy Act. Accordingly, the Board finds that the Part C Days issue was not included in Monogahela’s original hearing request. In addition, the record does not contain any documentation to confirm that Monogahela properly<sup>34</sup>

<sup>34</sup> See 73 Fed. Reg. 30190, 30240 (May 23, 2008) (explaining how the new 60-day time frame to add issues applies

added the Part C Days issue to the individual appeal prior to transfer to Case No. 09-0993G. Accordingly, the Board finds that Monogahela failed to document it appealed the Part C Days issue and the Board dismisses Monogahela from Case No. 09-0993G for lack of jurisdiction pursuant to 42 C.F.R. § 405.1840(b). Since Monogahela is not a participant in Case No. 09-0993G, Monogahela's request for EJR as it relates to Case No. 09-0993G is denied.

# 6 Sanford USD Medical Center (Provider No. 42-0027)

For Sanford USD Medical Center ("Sanford"), the Provider Representative included documentation at Tabs A and B confirming that Sanford's Notice of Program Reimbursement was issued on July 21, 2008 and that the Board received Sanford's appeal request 186 days later on January 23, 2009. In addition, the Provider Representative includes a copy of Sanford's hearing request; however, the hearing request does not include the Part C Days issue as one of the issues being appealed.

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 a cost claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary the request for hearing is received by the Board within 180 days of the date of receipt of the final determination by the provider. The NPR is presumed to have been received 5 days after the date of issuance by the intermediary as described at 42 C.F.R. § 405.1801 (a)(1)(iii).

The Board finds that Sanford's hearing request was not received by the Board within 180 days of the date of the receipt of the NPR (185 days after the issuance of the NPR) as required by 42 C.F.R. § 405.1835 and, therefore, it was not timely filed. Moreover, the Board notes that, even it were to have been timely filed, the appeal request does not include the Part C issue and, as such, the transfer at Tab G is fatally flawed because there was no issue to transfer. Accordingly, the Board dismisses Sanford from the appeal for lack of jurisdiction pursuant to 42 C.F.R. § 405.1840(b). Since Sanford is not a participant in Case No. 09-0993G, Sanford's request for EJR as it relates to Case No. 09-0993G is denied.

# 7 Baptist St. Anthony Health System (Provider No. 45-0231)

For Baptist St. Anthony Health System ("Baptist"), the Provider Representative included a copy of Baptist's individual appeal request (Model Form A, Request for Individual Appeal) at Tab B. However, similar to Naples, the documentation under Tab B for Baptist did not include the statement of the issues appealed that would have been attached to this Model Form A and, as a result, there is no proof that Baptist appealed the Part C Days issue to then be able to transfer that issue to the current group appeal. Similarly, the Model Form D (transfer) for Baptist at Tab G does not include a list of issues. 42 C.F.R. § 405.1835(b)(2008) requires that the appeal include an explanation

of the provider's dissatisfaction for each specific item at issue, why the Medicare payment is incorrect, and both how and why the payment must be determined differently. In this regard, Board Rule 7 (2008) required a statement of issues be included with the original hearing request and Rule 21.B requires that the original hearing request and the statement of the issue be included under Tab B. As Baptist failed to document it appealed the Part C Days issue, the Board dismisses Baptist from Case No. 09-0993G for lack of jurisdiction pursuant to 42 C.F.R. § 405.1840(b). Since Baptist is not a participant in Case No. 09-0993G, Baptist's request for EJRs as it relates to Case No. 09-0993G is denied.

# 8 Stevens Healthcare (Provider No. 50-0026)

For Stevens Healthcare ("Stevens"), the Provider Representative included a copy of Stevens' individual appeal request (Model Form A) at Tab B. However, similar to Naples, the documentation under Tab B for Stevens did not include the statement of issues appealed that would have been attached to this Model Form A and, as a result, there is no proof that Stevens appealed the Part C Days issue to then be able to transfer that issue to the current group appeal. Similarly, the Model Form D (transfer) for Stevens at Tab G does not include a list of issues. 42 C.F.R. § 405.1835(b)(2008) requires that the appeal include an explanation of the provider's dissatisfaction for each specific item at issue, why the Medicare payment is incorrect, and both how and why the payment must be determined differently. In this regard, Board Rule 7 (2008) required a statement of issues be included with the original hearing request and Rule 21.B requires that the original hearing request and the statement of the issue be included under Tab B.

Finally, the Board notes that there is no letter of representation at Tab H for Stevens as required by Board Rules 5 and 21.9.2 and that Stevens did not sign the transfer (rather it was only signed by Del Nord, a QRS employee).

As Stevens failed to document it had appealed the Part C Days issue and failed to confirm that it had appointed the Provider Representative, the Board dismisses Stevens from Case No. 09-0993G for lack of jurisdiction pursuant to 42 C.F.R. § 405.1840(b). Since Stevens is not a participant in Case No. 09-0993G, Stevens' request for EJRs as it relates to Case No. 09-0993G is denied.

B. Jurisdictional Determination for Remaining Participants (i.e., with the exception of the participants dismissed above)

The Board has determined that the appeals of the remaining participants involved with the instant EJRs Request either had an adjustment for the Part C days issue, or self-disallowed the days and that the participant appeals filed from a revised NPR have the appropriate adjustment to the Part C days issue within the revised NPR. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal<sup>34</sup> and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Accordingly, the Board finds that it has jurisdiction for the above-referenced group appeal and the underlying remaining participants.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2006 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (e.g., only circuit-wide versus nationwide).<sup>35</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit or the circuit within which they are located.<sup>36</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.<sup>37 38</sup>

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 remaining participants not dismissed above are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42

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<sup>35</sup> See 42 C.F.R. § 405.1837.

<sup>36</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>37</sup> See 42 U.S.C. § 1395oo(f)(1).

<sup>38</sup> The Medicare contractor, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the D.C. Federal District Court vacated in *Allina I*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

4/11/2019

 Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS (Electronic Mail w/Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)



## DEPARTMENT OF HEALTH & HUMAN SERVICES

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

### Electronic Delivery

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

#### **RE: *EJR Determination***

12-0281G QRS 2009 DSH Managed Care Part C Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 1, 2019 request for expedited judicial review (EJR), as well as the Providers' March 14, 2015 response to the Board's February 28, 2019 letter requesting additional information required to act upon the EJR submission. In its February 28<sup>th</sup> letter, the Board requested that Providers clearly identify the legal authority they were challenging and how it is binding on the Board, making EJR appropriate. The Board's determination regarding both jurisdiction and EJR is set forth below.

#### *Improper* Inclusion of Previously Dismissed Provider on the Schedule of Providers

The Board notes that the Schedules of Providers submitted by the Provider Representative with the EJR requests for Case No. 12-0281G *improperly* includes # 9, Danbury Hospital (Provider No. 07-0033) that the Board previously has issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeal. Accordingly, notwithstanding the Provider Representative's *improper* attempt to include the Provider on the Schedule of Providers, *this Provider is not currently part of Case No. 15-1423G* and, as such, cannot be considered in this EJR request. The Board will address the Provider Representative's failure to comply with Board Rules under separate cover pursuant to 42 C.F.R. § 405.1868.

#### Jurisdiction over the Appeals and EJR

The participants that *currently* comprise Case No. 12-0281G for this EJR request have filed appeals involving fiscal year 2009.

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

decision,” including documentation relating to jurisdiction.<sup>1</sup> Further, the regulations governing group appeals specify that jurisdiction “may be raised at any time.” To this end, Board Rule 20 requires the group representative to the Schedule of Providers and supporting jurisdiction documentation for a group case within 60 days of the full formation of the group and the requisite jurisdiction documentation for each provider in the Schedule of Providers is organized by Tabs A through H.

*A. Failure to Submit Cost Report Filing Documentation on All of the Providers*

The regulation, 42 C.F.R. § 405.1835(a)(3)(ii) (2011) permits a provider to file an appeal with the Board if the final determination is not issued (through no fault of the provider) within 12 months of the *date of receipt* by the Medicare contractor of the provider’s perfected cost report *no later than 180 days* after the expiration of the 12 month period for the issuance of the contractor’s determination. In order to ensure compliance with § 405.1835(a)(3)(ii) (2011), Board Rule 7.4 (2013) requires that, if a Provider is appealing the Medicare Contractor’s failure to issue a Notice of Program Reimbursement (NPR), Providers must submit the following information with its original appeal request:

- the certification page of the perfected or amended cost report,
- the certified mail receipt evidencing the Intermediary’s receipt of the as-filed and any amended cost reports,
- the Intermediary’s letter/e-mail acknowledging receipt of the as-filed and any amended cost reports,
- evidence of the Intermediary’s acceptance or rejection of the as-filed and any amended cost reports, and
- the documentation described in Rule 7.2, as relevant, if the issue(s) being appealed involves one or more self-disallowed items [March 2013]

Further, Board Rule 21.A (2013) requires that this information be placed under Tab A of the jurisdictional documents for the relevant provider. In this case, the Providers’ Representative included *only* an unsigned certification page from the relevant cost report for all of the Providers in this group with one exception, Provider #15 (Indian River Memorial Hospital).<sup>2</sup> Further, the Providers’ Representative failed to include any of the above-described information required under Board Rule 7.4 (2013). Accordingly, the Board is unable to confirm whether any of the Providers included in Group Case No. 12-0281G timely filed an appeal pursuant to § 405.1835(a)(3)(ii) (2011) and must dismiss all of the Providers in Group Case No. 12-0281

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<sup>1</sup> Similarly, the Board has the authority under 42 U.S.C. § 1395oo and 42 C.F.R. 405.1868 to make rules and establish procedures that are necessary to carry out the provisions of § 1395oo and the regulation at 42 C.F.R §§ 405.1835-405.1889. See 42 C.F.R. § 405.1869(a).

<sup>2</sup> See *infra* note 3 confirming that, notwithstanding the lack of documentation, the Provider Representative is representing that Provider #15 did not timely appeal the non-issuance of the NPR.



because the Board is unable to determine if each of these Providers is entitled to appeal under 42 C.F.R. § 405.1835(a)(3)(ii) (2011).<sup>3</sup>

*B. No Proof of Receipt of Appeals by the Board for Any of the Providers*

Since all of the appeals were filed after August 21, 2008, Board Rule 21.B requires that the Schedule of Providers include copies of the proof of delivery (UPSP, FedEx, UPS tracking) for both the original appeal and the addition of issues be included under Tab B for each provider listed in that Schedule to confirm that they were in fact filed *and* the filing was timely. However, there is only documentation of mailing in the record based on the tracking number listed on the certification page for each appeal included at Tab B. Thus, for all of the Providers included in the Schedule of Providers for Case No. 12-0281G, the Group Representative failed to include the requisite proof of delivery.

*C. Irrelevance of NPRs included for Provider ## 19, 20, 21, and 24*

Provider # 19 Memorial Hospital (Provider No. 14-0185), Provider # 20 Stormont-Vale RHC (Provider No. 17-0086), Provider #21 Via Christi Regional Medical Center (Provider No. 17-0122), and Provider #24 Mary Lanning Memorial Hospital (Provider No. 28-0032, the Providers' Representative included *both* the unsigned cost report certification page *and* a copy of an NPR in the jurisdictional documents. By including a copy of the NPR for Provider ## 19, 20, 21, and 24 in the jurisdictional documents for Case No. 12-0281G, it is unclear whether the Provider Representative is asserting that those Providers filed an appeal both from the nonissuance of an NPR and from their subsequent original NPR and transferred the Part C Days issue from that both of those appeals into Case No. 12-0281G. As previously discussed, the Board has dismissed Provider ##19, 20, 21, and 24 from being participants in this case based on defects in their appeal of the non-issuance of an NPR included at Tab B.<sup>4</sup> That leaves only the question of what significance, if any, the copy of the NPR has. However, the Board need not resolve that question, because:

1. With respect to Provider ## 21 and 24, there is no evidence in the file to suggest that they appealed the original NPR. Further, the Board has not identified an appeal of the original NPR Provider ##21 and 24 for FY 2009 and the transfer included at Tab H only relates to the appeal of the nonissuance of an NPR.
2. With respect to Provider ## 19 and 20, the Board is aware that these providers did separately appeal the original NPR. However, there is no evidence to suggest that they

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<sup>3</sup> The Board notes that, even if the Board were to overlook this documentation deficiency and were to assume that the Providers' Representative correctly listed the date that the Medicare contractor received the cost report at issue for each Provider in the Schedule of Providers, it is clear by the Providers' Representative's admission that Provider ## 1, 2, 3, 4, 8, 9, 12, 15, 16, 17, 20 and 22 would have filed their appeals more than 180 days after the expiration of the 12-month period for issuing the NPR and that these appeals would not have been timely filed with the Board.

<sup>4</sup> The Board notes that the appeal request included at Tab B predates the date of the NPR included at Tab C for Provider ## 19, 20, and 21. For Provider #24, the NPR is undated but the appeal request clearly states it is appealing from the nonissuance of the NPR.

ever requested a transfer from the relevant original NPR appeal *into Case No. 12-0281G*,<sup>5</sup> Moreover, even if Provider ##19 and 20 made such a request to transfer to *Case No. 12-0281*, the Board would deny it as duplicative because Provider ##19 and 20 have already transferred the Part C Days issue from their original NPR appeal to another group appeal (Case Nos. 13-3941G and 13-2028G respectively). In this regard, Board Rule 4.5 (2013) prohibits appealing an issue in more than one appeal.

Based on the above, the Board concludes that the inclusion of the NPR for Provider ##19, 20, 21, and 24 is irrelevant and has no bearing on the Board's jurisdiction determinations for these Providers in Case No. 12-0281G.

### Decision of the Board

The Board hereby dismisses Case No. 12-0281G in its entirety for lack of jurisdiction based on the following findings:

1. The Board finds that the Group Representative failed to comply with Board Rules 7.4, 21.A, and 21.B for each of the Providers listed in the Schedule of Providers for Case No. 12-0281G and, as a result, the Board cannot establish that the Provider was entitled to appeal rights under 42 C.F.R. § 405.1835(a)(3)(ii) due the nonissuance of an NPR.<sup>6</sup>
2. It makes the additional finding on Provider ## 19, 20, 21, and 24 that the inclusion of the NPR for these Providers at Tab C is irrelevant and has no bearing on the Board's jurisdiction determinations for these Providers in Case No. 12-0281G.


As the Board lacks jurisdiction over all of the participants in Case No. 12-0281G, the Board hereby denies the Providers' request for EJR for Case No. 12-0281G. Further, since the Board has dismissed Case No. 12-0281G in its entirety, it is now closed. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

#### Board Members Participating:

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

#### For the Board:

4/12/2019

 Clayton J. Nix

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

cc: Pam VanArsdale, NGS (Electronic Mail w/Schedules of Providers)  
Wilson Leong, (Electronic Mail w/Schedules of Providers)

<sup>5</sup> The transfer requests at Tab H for Provider ## 19 and 20 predate the NPR included at Tab C.

<sup>6</sup> See 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840.



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Provider Reimbursement Review Board  
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William Galinsky  
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Baylor Scott & White Health  
2401 South 31<sup>st</sup> Street  
MS-AR-M148  
Temple, TX 76508

Bill Tisdale  
Director JH, Provider Audit & Reimbursement  
Novitas Solutions, Inc.  
Union Trust Building  
501 Grant Street, Suite 600  
Pittsburgh, PA 15219

Re: Scott & White Hospital Brenham  
Provider No. 45-0187,  
FYE 12/31/2015  
PRRB Case No. 19-1450

Dear Mr. Galinsky and Mr. Tisdale:

The Provider Reimbursement Review Board (“Board”) is in receipt of the Provider’s appeal request. The background of the case and the decision of the Board are set forth below.

**Background**

On February 21, 2019, the Board received the provider’s individual appeal based on a determination dated August 27, 2018.<sup>1</sup>

**Decision of the Board**

The Board finds that the Provider’s appeal request is jurisdictionally deficient as the Provider failed to submit the final determination under appeal. Further, the provider failed to specify *any* issues in dispute or, in the alternative, to provide *any* supporting documentation for the issue(s).

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835, a provider has a right to a hearing on a final contractor or Secretary determination for the provider’s cost reporting period if it is dissatisfied with the contractor’s final determination, the amount in controversy is \$10,000 or more (\$50,000 for a group), and the request for a hearing is no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

Pursuant to 42 C.F.R. § 405.1835(b), if a Provider’s appeal request does not meet the requirements of paragraphs (b)(1) through (b)(3) of the same section, the Board may dismiss

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<sup>1</sup> On the February 18, 2019 Model Form A, the Provider referenced August 27, 2018 as the Notice of Final Determination Date but did not attach a copy of the referenced determination.

with prejudice the appeal, or take any other remedial action it considers appropriate. Paragraphs (b)(1) through (b)(3) state in part that the following must be included in the Provider's request:

- (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of the same section, including a specific identification of the final contractor or Secretary determination under appeal.
- (2) A separate explanation for each specific item under appeal and a description of how the provider is dissatisfied with the specific aspects of the final determination.
- (3) A copy of the determination, including any other documentary evidence the provider considers necessary to satisfy the hearing request requirements.

Because the Provider failed *both* to submit the final determination under appeal *and* to explain the specific items under appeal, the Provider did not meet the regulatory requirements for filing an appeal before the Board. Therefore, the Board finds that dismissal is appropriate and closes Case No. 19-1450.

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

Board Members Participating:

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

For the Board:

4/12/2019

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X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services



**Electronic Delivery**

James Ravindran  
Quality Reimbursement Services, Inc.  
150 N. Santa Anita Avenue  
Suite 570A  
Arcadia, CA 91006

**RE: *Expedited Judicial Review Determination for PRRB Case Numbers:***

- 10-1172GC QRS Empire Health Services 2005-2008 Part C CIRP Group
- 17-0555GC QRS Empire Health 2005-2007 SSI – Part C Days CIRP Group
- 15-3484GC QRS Empire Health 2008 SSI – Part C Days CIRP Group
- 16-2596GC QRS UW Medicine 2006 SSI Part C Days CIRP Group
- 15-0792GC QRS UW Medicine 2011-2012 Part C Days CRIP Group
- 15-0794GC QRS UW Medicine 2011-2012 SSI Part C Days CIRP Group
- 17-0956GC QRS UW Medicine 2013-2014 Part C Days CIRP Group
- 17-0959GC QRS UW Medicine 2013-2014 SSI Part C Days CIRP Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“PRRB” or “Board”) has reviewed the Providers’ March 20, 2019 request for expedited judicial review (“EJR”) of the above referenced appeals. The Board’s jurisdictional determination and decision regarding the EJR request is set forth below.

**Issue in Dispute**

The issue in these appeals is:

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

**Statutory and Regulatory Background: Medicare DSH Payment**

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

<sup>1</sup> Providers’ EJR request at 1.

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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

[T]he 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.<sup>11</sup>

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<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> Emphasis added.

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

<sup>11</sup> Emphasis added.

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

### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

With the creation of Medicare Part C in 1997,<sup>16</sup> Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part

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<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

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

A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.<sup>17</sup>

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

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

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

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

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

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

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

<sup>20</sup> *Id.* (emphasis added).

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).



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

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

### **Providers’ Request for EJR**

The Providers explain that “[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The ‘2004 Rule’) The Board is bound by the 2004 Rule.”<sup>29</sup> Accordingly, the Providers contend that the Board should grant their request for EJR.

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

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<sup>22</sup> *Id.* at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

<sup>28</sup> *Id.* at 943-945.

<sup>29</sup> EJR Request at 1.

### 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.

### Improper Inclusion of Previously Dismissed Provider on the Schedule of Providers

At the outset, the Board notes that the Schedule of Providers for Case No. 15-3484GC, submitted by the Provider Representative for this EJR request, *improperly* includes a Provider that the Board previously denied the transfer to this group appeal. Specifically, the Board denied the request to transfer the Medicare Managed Care Part C days issue for Deaconess Medical Center (Provider No. 50-0044, FYE 9/30/2008). On February 23, 2016, the Board issued a decision in which it denied jurisdiction over the sole issue the Provider used to establish its individual appeal, Case No. 13-0041 and, therefore, found that the Provider did not establish a jurisdictionally valid appeal to which issues could be properly or timely added. As a result, the Board also denied the Provider's transfer requests, including the request to transfer the SSI Fraction Part C Days issue to this group. In response to the Provider's request for reconsideration of this decision, the Board upheld its previous decision on June 17, 2016.

Accordingly, notwithstanding the Provider Representative's *improper* attempt to include the Provider on the Schedule of Providers, Deaconess Medical Center (Provider No. 50-0044, FYE 9/30/2008) is *not currently* part of Case No. 15-3484GC and, as such, the Board *cannot* consider it as part of this EJR request for that appeal. The Board will address the Provider Representative's failure to comply with Board Rules under separate cover pursuant to 42 C.F.R. § 405.1868.

### Jurisdiction for the Group Participants

The participants that *currently* comprise the group appeals within this EJR request have filed appeals involving fiscal years 2005 through 2008, and 2011 through 2014.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").<sup>30</sup> 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.<sup>31</sup>

<sup>30</sup> 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.).

<sup>31</sup> *Bethesda*, 108 S. Ct. at 1258-59.

On August 21, 2008, new regulations governing the Board were effective.<sup>32</sup> 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*”).<sup>33</sup> 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.<sup>34</sup>

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant’s appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>35</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

#### A. Jurisdictional Determination On Certain Specific Individual Participants

At the outset, the Board notes that a Board finding of jurisdiction is a prerequisite to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority request “[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision,”<sup>36</sup> including documentation relating to jurisdiction. Similarly, the regulations governing group appeals specify that jurisdiction “may be raised at any time.”<sup>37</sup>

<sup>32</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>33</sup> 201 F. Supp. 3d 131 (D.D.C. 2016)

<sup>34</sup> *Id.* at 142.

<sup>35</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

<sup>36</sup> 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which included a decision on both jurisdiction and the EJR request).

<sup>37</sup> 42 C.F.R. 405.1837(e)(2) states: “*The Board may make jurisdictional findings under § 405.1840 at any time, including, but not limited to, following a request by the providers for the jurisdictional findings. The providers may request jurisdictional findings by notifying the Board in writing that the group appeal is fully formed, or that the providers believe they have satisfied all of the requirements for a group appeal hearing request, and the Board may proceed to make jurisdictional findings.*”

1. *Case No. 17-055GC—Participant 1, Deaconess Medical Center, Provider No. 50-0044, FYE 12/31/2007*

The Board finds that it does not have jurisdiction over Deaconess Medical Center (FYE 12/31/2007) in Case No. 17-0555GC because the Provider has appealed from a revised Notice of Program Reimbursement (“NPR”) that did not adjust the SSI percentage.

The Code of Federal Regulations provides for an opportunity for a revised Notice of Program Reimbursement. The principles from the revised NPR regulations can be applied to appeals from revised hospice cap determinations, as well. 42 C.F.R. § 405.1885 (2016) provides in relevant part:

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

42 C.F.R. § 405.1889 (2016) explains the effect of a cost report revision:

(a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

(b)(1) Only those matters that are *specifically revised* in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(2) Any matter that is not *specifically revised* (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.<sup>38</sup>

Adjustment No. 5 on the Provider’s audit adjustment report is “To adjust the cost report to include the hospital’s current SSI percentage publication.”<sup>39</sup> However, there is no adjustment to the SSI percentage as the Provider’s SSI percentage stays the same (8.63).<sup>40</sup> Because the SSI percentage was not “specifically” adjusted, the Board finds that, pursuant to § 405.1889(b)(2), it does not have jurisdiction over Deaconess Medical Center’s revised NPR appeal for FYE 12/31/2007 in Case No. 17-055GC. Since Deaconess Medical Center is not a participant in Case

<sup>38</sup> (Emphasis added.)

<sup>39</sup> Schedule of Providers in Case No. 17-0555GC at Tab 1D.

<sup>40</sup> The group issue is whether Part C days should be excluded from the SSI fraction.

No. 17-0555GC, the Board hereby denies Deaconess Medical Center's request for EJR as it relates to Case No. 17-0555GC.

2. *Case No. 17-0555GC—Participant 3, Valley Hospital Medical Center, Provider No. 50-0019, FYE 12/31/2006*

The Board finds that it does not have jurisdiction over Valley Hospital Medical Center (FYE 12/31/2006) in Case No. 17-0555GC because the Provider also appealed from a revised NPR that did not specifically adjust the SSI percentage. Similar to Participant 1 discussed above, Adjustment 5 on Valley Hospital Medical Center's audit adjustment report is "To adjust the cost report to include the hospital's current SSI percentage."<sup>41</sup> However, there is no adjustment to the SSI percentage as the Provider's SSI percentage stays the same (4.09). Because the SSI percentage was not "specifically" adjusted, the Board finds that, pursuant to § 405.1889(b)(2), it does not have jurisdiction over Valley Hospital Medical Center's revised NPR appeal for FYE 12/31/2006 in Case No. 17-0555GC. Since Valley Hospital Medical Center is not a participant in Case No. 17-0555GC, the Board hereby denies Valley Hospital Medical Center's request for EJR as it relates to Case No. 17-0555GC.

3. *Striking Issue Statement Listed on the Schedule of Providers for Case Nos. 15-0794GC, 16-2596GC, and 17-0959GC*

As explained below, the Board finds that the DSH SSI Fraction/Part C issue is the only group issue in Case Nos. 15-0794GC, 16-2596GC, and 17-0959GC and does not include or encompass either the Inpatient Rehabilitation Facility ("IRF") Low Income Patient ("LIP") Part C Days issue *or* an issue involving the Medicare Part A days. The issue statement on the Schedule of Providers for Case No. 17-0959GC submitted on March 18, 2019 with this EJR request improperly reads as follows:

Whether the SSI percentages used in the Medicare DSH payment calculation under 42 CFR 412.106(b)(2)(i), and the IRF LIP payment calculation under 42 CFR 412.624(e)(2), include the correct number of the Provider's SSI-entitled Medicare Part A patients and violates the applicable statutes and regulations because the denominator includes inpatient days Medicare classifies as not covered and/or not paid while the numerator is restricted to only paid days.

The same issue statement (almost verbatim) was included on the Schedule of Providers for 15-0794GC and 16-2596GC. There are several things to note regarding these issue statements. First, the purported group issue statement contains two issues – Part A SSI Percentage for DSH and for LIP. PRRB Rule 13 states, "The matter at issue in a group appeal must involve a single common question of fact or interpretation of law, regulation, or CMS policy or ruling." Second, the issue statement is about Medicare Part A patients in the SSI percentage, and it does *not* discuss or refer to Part C patients in the SSI percentage, *which is the issue stated in the group appeal request*. Third, the Board does not have jurisdiction over IRF LIP issues as confirmed by the D.C. Circuit in *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018) ("*Mercy*").

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<sup>41</sup> Schedule of Providers in Case No. 17-0555GC at Tab 3D.

Accordingly, the Board hereby strikes the issue statement included on the Schedule of Providers for Case Nos. 15-0794GC, 16-2596GC, and 17-0959GC and references the original issue statement included in the group appeal request which is consistent with the EJR request.

**B. Jurisdictional Determination for Remaining Participants (i.e., with exception of the previously dismissed participant and the providers dismissed above)**

The Board has determined that the remaining participants' appeals involved with the instant EJR Request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R and that the participant appeals filed from a revised NPR have the appropriate adjustment to the Part C days issue within the revised NPR. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal<sup>42</sup> and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the referenced group appeals and the underlying remaining participants.

**Board's Analysis Regarding the Appealed Issue**

The appeals in these EJR requests involve the 2006 through 2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (e.g., only circuit-wide versus nationwide).<sup>43</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>44</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

**Board's Decision Regarding the EJR Request**

The Board finds that:

- 1) Deaconess Medical Center, Provider No. 50-0044, FYE 9/30/2008, is not part of the EJR request as it relates to Case No. 15-3484GC because the Board has previously denied jurisdiction over the Provider in its individual appeal of FYE 9/30/2008 and denied the transfer to this group;
- 2) It does not have jurisdiction to hear the appeals for: (a) Deaconess Medical Center (FYE 12/31/2007) in Case No. 17-0555GC, and (b) Valley Hospital Medical Center

<sup>42</sup> See 42 C.F.R. § 405.1837.

<sup>43</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>44</sup> See 42 U.S.C. § 1395oo(f)(1).

(12/31/2006) in Case No. 17-0555GC; and, thus, these participants are dismissed from Case No. 17-0555GC and from this EJRB Determination;

- 3) It has jurisdiction over the matter for the subject years and that the remaining participants in these group appeals are entitled to a hearing before the Board;
- 4) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 5) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 6) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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

**Board Members Participating:**

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

**For the Board:**

4/12/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators  
John Bloom, Noridian Healthcare Solutions



DEPARTMENT OF HEALTH & HUMAN SERVICES

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**RE: *Request to Consolidate Individual Appeals***

Provider No: 05-0233  
FYE: 9/30/1992, 9/30/1993, 9/30/1994  
Case Nos.: 19-0573, 19-0572, 19-0570

Dear Mr. Reid and Ms. Frewert,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeals in response to the Sharp Cabrillo Hospital's ("Sharp" or "Provider") Request to Consolidate the individual appeals. The Board's decision is set forth below.

**BACKGROUND:**

The Provider was issued three separate revised Notice of Program Reimbursements ("NPR") for each of the above cases on July 13, 2018, for fiscal year end ("FYE") 9/30/1992, 9/30/1993, and 9/30/1994. On December 26, 2018, the Provider filed three separate appeal requests with the Board that identified the following issue:

- 1) IPPS Base Year Transfer-Discharge Data – Provider claims the federal Inpatient Prospective Payment Systems (IPPS) base year cost per discharge known as the "standardized amount" for operating costs and capital costs was understated. Provider claims the discharge count used to establish the "standardized amount" included discharges that were considered "Transfer DRGs" and should have excluded the Transfer DRG's from the discharge count;<sup>1</sup>

The Provider further filed a Request to Consolidate the Individual Appeals for the same single issue of the IPPS Base Year Transfer-Discharge Data listed above.

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<sup>1</sup> Provider's Request for Hearing, PRRB Case No. 19-0570 (Dec. 26, 2018); Provider's Request for Hearing, PRRB Case No. 19-0572 (Dec. 26, 2018); Provider's Request for Hearing, PRRB Case No. 19-0573 (Dec. 26, 2018).



**BOARD'S DECISION:**

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2011) provides in relevant part:

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

42 C.F.R. § 405.1889 (2011) explains the effect of a cost report revision:

(a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

...If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over Sharp's appeals from their revised NPRs, for the IPPS Base Year Transfer-Discharge Data because, as explained more fully below, the IPPS rate was not specifically adjusted in the Provider's revised NPRs.

Sharp's revised NPR was issued as the result of the Board issuing a SSI remand of earlier SSI appeals.<sup>2</sup> As such, the IPPS rate was not the subject of the revised NPR, and it was not adjusted. This bears out in the Adjustment Reports. As per the Adjustment Reports, the only adjustments were to the *Disproportionate Share Adjustment (to incorporate the providers remand SSI% election)*, and *Total Capital Payments Under 100% Federal Rate (To adjust the capital payments based on the SSI remand)*.<sup>3</sup>

Once the RNPR was issued, the Provider appealed the IPPS Base Year Transfer-Discharge Data in all three cases.<sup>4</sup> As this issue was not part of the reopening appealed (no adjustments to these components), and it is not related to the SSI Percentage or Capital Payments as adjusted, the Board would lack jurisdiction from a revised NPR. Had the Provider wanted to preserve its appeal rights of IPPS Base Year Transfer-Discharge Data, it could have appealed those issues from the original NPR.

The revised NPR regulations discussed above make clear that a Provider can only appeal items that are specifically adjusted from a revised NPR. The Provider has appealed IPPS Base Year Transfer-Discharge Data, which was not adjusted in the revised NPR. Accordingly, the Board dismisses the appeals in each of these three individual cases pursuant to 42 C.F.R. § 405.1889.

Further, as the Board does not have jurisdiction for these cases, the Board hereby denies the Request for Consolidation.

### CONCLUSION:

The Board finds that it does not have jurisdiction over Sharp's appeals from their revised NPRs and, thus, dismisses the IPPS Base Year Transfer-Discharge Data issue in each of these three individual cases. As the Board does not have jurisdiction for these cases, the Board hereby denies the Request for Consolidation. As there are no other remaining issues in these cases, they are now closed.

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

#### Board Members Participating:

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

#### For the Board:

4/18/2019

X Clayton J. Nix

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

<sup>2</sup> See SSI Remand letter submitted by the Provider December 27, 2018.

<sup>3</sup> Adjustment Report from rNPR (Jul. 13, 2018).

<sup>4</sup> *Supra*, note 1.

cc: Edward Lau, Esq., Federal Specialized Services  
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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**RE: *Jurisdictional Determination/Dismissal for Untimely Filing***  
Wexner Heritage Village  
Provider No. 36-5026  
FYE 12/31/2015  
Case No. 19-1577

Dear Mr. Gilbert and Ms. Cummings:

This case involves Wexner Heritage Village's ("Wexner's") appeal of its Notice of Program Reimbursement regarding fiscal year ending ("FYE") December 31, 2015. Following review of the request to establish an individual appeal, the Provider Reimbursement Review Board ("Board") finds that Wexner failed to file its request for hearing ("RFH") in a timely manner and must dismiss its appeal, as explained below.

**BACKGROUND**

By paper submission dated February 11, 2019, the group representative submitted a *Request to Form Mandatory Group Appeal* ("RFH") in order to establish an individual appeal (*PRRB Case No. 19-1577*). This appeal is based on a Notice of Program Reimbursement ("NPR") dated November 15, 2017. Accordingly, the appeal was filed 453 days after the issuance of the NPR.<sup>1</sup> On the same day it filed its RFH, the Provider filed a Request for Good Cause Extension with the Board regarding its untimely submission.

**BOARD'S ANALYSIS AND DECISION**

**APPLICABLE REGULATIONS AND AUTHORITY**

Under 42 C.F.R. § 405.1835(a) (2015), a provider has a right to a Board hearing for specific items claimed for a cost reporting period covered by a final contractor or Secretary determination as long as the provider meets certain jurisdictional requirements. One of the requirements is that the Board must receive the provider's RFH within 180 days of the date of receipt of the provider's final determination.<sup>2</sup> With respect to the provider, the applicable regulation defines

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<sup>1</sup> See Provider Request for Appeal, PRRB Case No. 19-1577.

<sup>2</sup> 42 C.F.R. § 405.1835(a)(3).

the phrase “date of receipt” as the date a document or other material is received by the provider. More specifically, the regulatory definition states that the date of receipt of documents in proceedings before a reviewing entity (such as the Board) is presumed to be 5 days after the date of issuance of a contractor notice or a reviewing entity notice. This presumption, which is otherwise conclusive, is rebuttable if the provider can show by a preponderance of the evidence that the documents were received on a later date.<sup>3</sup> With respect to the Board, the date of receipt is defined as the date of delivery to the Board for documents transmitted by a nationally-recognized next-day courier, as evidenced by the courier’s tracking bill, or date stamped “received” if submitted by regular mail, hand or non-nationally recognized next-day courier.<sup>4</sup>

In addition, the regulations permit that the Board may grant a provider a good cause extension of the time limit for requesting a Board hearing if the provider can demonstrate in writing that it could not reasonably be expected to file timely due to circumstances beyond its control.<sup>5</sup> Otherwise, the regulations specifically state that a provider’s RFH that the Board receives after the applicable 180-day time limit must be dismissed by the Board.<sup>6</sup>

#### **ANALYSIS AND JURISDICTIONAL DETERMINATION**

As noted prior, the Medicare Contractor issued the Provider’s NPR on November 15, 2017. The Board received Wexner’s RFH on February 11, 2019, 453 days after the date of issuance of the NPR. The Federal Rules of Civil Procedure state that “if the last day is a Saturday, Sunday, or legal holiday, the period continues to run until the end of the next day that is not a Saturday, Sunday, or legal holiday.”<sup>7</sup> Based on this procedure, the appeal was due to the Board on Monday, May 14, 2018. This exceeds the 180-day time frame (including the five day presumption) for filing an appeal with the Board.

In its Request for Good Cause Extension, filed simultaneously with its RFH, the Provider acknowledges that the RFH was not submitted within 180 days of its receipt of the NPR.<sup>8</sup> The Provider states that the MAC’s “refusal to correct its erroneous adjustment based on clear evidence and its delay in responding to the Provider’s reopening request has stripped the Provider of its opportunity to timely appeal this issue.”<sup>9</sup> In an attached affidavit, the Provider adds the following information to this explanation:

My communications with the MAC auditor led me to believe, and I did so believe in good faith, that the MAC would reconsider its disallowance of the Provider’s bad debt when the Provider supplied the MAC with documentation of the Provider’s bad debts collection policy. In good faith and reasonably relying upon the

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<sup>3</sup> 42 C.F.R. § 405.1801(a).

<sup>4</sup> 42 C.F.R. § 405.1801(b).

<sup>5</sup> 42 C.F.R. § 405.1836(b).

<sup>6</sup> 42 C.F.R. § 405.1836(a).

<sup>7</sup> FED.R.CIV.P. 6(a)(1)(c).

<sup>8</sup> Provider’s Request for Good Cause Extension at 1 (Feb. 11, 2019).

<sup>9</sup> *Id.*

belief that the MAC would reconsider and reverse its disallowance, we did not file an appeal with the Provider Reimbursement Review Board while we waited for the MAC to reopen the Provider's FY 2015 cost report.<sup>10</sup>

Discussions between the MAC and the Provider regarding reopening a NPR are outside of the scope of Board jurisdiction and authority. The Board's Rules, in fact, provide the ability to withdraw an appeal if the MAC has agreed to reopen an NPR,<sup>11</sup> and the Reinstatement procedures in Rule 47 permit preservation of the appeal for up to three years of the withdrawal of the appeal.<sup>12</sup>

The Board finds that the Provider failed to demonstrate that it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control. In this regard, the Board notes that the filing deadline was May 14, 2018 and Wexner filed its RFH on February 11, 2019, *nearly 9 months beyond that filing deadline*. Further, it is the Provider's responsibility to preserve its right to appeal, and it cannot rely on the MAC to accomplish a non-guaranteed reopening or other modification of a NPR.


In summary, the Board finds that Wexner's RFH was filed untimely pursuant to 42 C.F.R. § 405.1835(a) (2015) and denies Wexner's request for a good cause extension under 42 C.F.R. § 405.1836. Accordingly, the Board hereby dismisses this case. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

4/18/2019

 Clayton J. Nix

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

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Wilson Leong, Federal Specialized Services

<sup>10</sup> *Id.*, Affidavit of Thomas McDermott at para. 16.

<sup>11</sup> PRRB Board Rule 46 (Aug. 29, 2018).

<sup>12</sup> *Id.* at Rule 47.



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

James Ravindran  
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Quality Reimbursement Services, Inc.  
150 N. Santa Ana Ave., Suite 570A  
Arcadia, CA 91006

Byron Lamprecht  
Supervisor – Cost Report Appeals  
WPS Government Health Administrators  
2525 N 117th Ave., Suite 200  
Omaha, NE 68164

RE: Denial of Transfer and Dismissal of Appeal  
Quorum Health CY 2006 DSH SSI Percentage CIRP Group  
Provider Nos.: 05-0194  
FYE: 7/31/2006  
PRRB Case No.: 18-1829GC

Dear Mr. Ravindran and Mr. Lamprecht:

On August 30, 2018, Quorum Health Corporation (“Quorum”) filed a request to transfer Watsonville Community Hospital (Provider No. 05-0194) (“Watsonville”), and the case’s sole issue (DSH Payment – SSI Percentage), from PRRB Case No. 18-0333 to a new group appeal created based on a simultaneously filed Request to Form a Group Appeal. PRRB Case No. 18-1829GC was created in response to the Request to Form a Group Appeal with Watsonville as its sole member.

However, Case No. 18-0333 was dismissed on January 23, 2018 because the Request for Hearing was received after the 180 day filing period had expired.<sup>1</sup> Furthermore, Quorum’s Request for Form a Group Appeal was filed on August 30, 2018, 447 days after the NPR was issued and well after the applicable 180-day appeal period for this particular Final Determination<sup>2</sup> had lapsed. Accordingly, Quorum’s Request to Form a Group Appeal was untimely filed pursuant to 42 C.F.R. § 405.1835(a)(3).

Based on these facts, the Board denies Quorum’s Request to Transfer Issue to a Group Appeal because there was no valid provider nor existing issue following the dismissal of Case No. 18-0333. Further, the Board denies Quorum’s Request to Form a Group Appeal for failure to timely file the appeal. Finally, the Board hereby dismisses Watsonville from Case No 18-1829 and, dismisses Case No 18-1829 because Watsonville was the only provider in this appeal.

<sup>1</sup> See PRRB Case No. 18-0333, Dismissal Letter (Jan. 23, 2018) (Provider’s RFH was due to the Board by December 11, 2017, but was filed on December 14, 2017, 183 days after the presumed receipt of the NPR, and was deemed filed untimely and dismissed).

<sup>2</sup> NPR was issued on June 9, 2017, and any appeal was due within the statutorily provided 180 day window, and was due to the Board on December 11, 2017.

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

Board Members Participating:

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

For the Board:

4/19/2019

**X** Robert A. Evarts, Esq.

Robert A. Evarts, Esq.  
Board Member  
Signed by: Robert A. Evarts -S

cc: Wilson Leong, Federal Specialized Services





DEPARTMENT OF HEALTH & HUMAN SERVICES

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Provider Reimbursement Review Board  
1508 Woodlawn Drive, Suite 100  
Baltimore, MD 21207  
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**Electronic Delivery**

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

**RE: *EJR Determination***

13-2707GC – QRS TMH 2007 DSH Medicare Managed Care Part C Days Group  
14-4110GC – QRS Houston Methodist 2009 DSH SSI Fraction Medicare Mngd Care Part C Days  
14-4119GC – QRS Houston Methodist 2008 DSH SSI Fraction Medicare Mngd Care Part C Days  
14-4127GC – QRS Houston Methodist 2008 DSH Medicaid Fraction Medicare Mngd Care Part C Days  
14-4361GC – QRS Houston Methodist 2009 DSH Medicaid Fraction Medicare Mngd Care Part C Days  
15-2920GC – QRS Houston Methodist 2010 DSH SSI Fraction Medicare Mngd Care Part C Days  
17-1078GC – QRS Houston Methodist 2005 DSH SSI Fraction Medicare Mngd Care Part C Days  
17-1079GC – QRS Houston Methodist 2005 DSH Medicaid Fraction Medicare Mngd Care Part C Days

Dear Mr. Ravindran :

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ April 1, 2019 request for expedited judicial review (“EJR”) for the appeals referenced above. The Board’s determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

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

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<sup>1</sup> Providers’ EJR request at 1.

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> (Emphasis added.)

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

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

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

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.<sup>12</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

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<sup>11</sup> (Emphasis added.)

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

including HMO days in the SSI/Medicare percentage [of the DSH adjustment].<sup>14</sup>

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

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

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

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

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

... We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense,

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

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

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,<sup>24</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.<sup>25</sup> However, the Secretary has not acquiesced to that decision.

<sup>20</sup> *Id.* (emphasis added).

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> 72 Fed. Reg. at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the

More recently, in *Allina Health Services v. Price* (“*Allina I*”),<sup>26</sup> the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>27</sup> The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>28</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers’ Request for EJR**

The Providers explain that “[b]ecause the Secretary has not acquiesced to the decision in *Allina I*], the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The ‘2004 Rule’) The Board is bound by the 2004 rule.”<sup>29</sup> Accordingly, the Providers contend that the Board should grant their request for EJR.

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

### **Decision of the Board**

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

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2005, 2007, 2008, 2009 and 2010.

For purposes of Board jurisdiction over a participant’s appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a “self-

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Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

<sup>28</sup> *Id.* at 943-945.

<sup>29</sup> Providers’ EJR Request at 1.

disallowed cost,” pursuant to the Supreme Court’s reasoning set out in *Bethesda Hospital Association v. Bowen* (“*Bethesda*”).<sup>30</sup> 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.<sup>31</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>32</sup> 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*”).<sup>33</sup> 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.<sup>34</sup>

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant’s appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>35</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

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<sup>30</sup> 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.).

<sup>31</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>32</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>33</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>34</sup> *Id.* at 142.

<sup>35</sup> *See* 42 C.F.R. § 405.1889(b)(1) (2008).

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. The appeals of revised NPRs have adjustments to the Part C Days issue as required by 42 C.F.R. § 405.1889. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>36</sup> The appeals 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 in each case.

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2005, 2007, 2008, 2009 and 2010 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>37</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>38</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

<sup>36</sup> See 42 C.F.R. § 405.1837.

<sup>37</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>38</sup> See 42 U.S.C. § 1395oo(f)(1).



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

Board Members Participating:

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

FOR THE BOARD:

4/19/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Justin Lattimore, Novitas (Electronic Mail w/Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Mail**

Isaac Blumberg  
Blumberg Ribner, Inc.  
315 South Beverly Drive  
Suite 505  
Beverly Hills, CA 90212-1925

**RE: Expedited Judicial Review Determination**

- 18-0500G BRI Independent Hosps 2006 Medicare HMO Part C Days Medicare Fraction Group
- 18-0501G BRI Independent Hosps 2006 Medicare HMO Part C Days Medicaid Fraction Group
- 18-0515G BRI Independent Hosps 2011 Medicare HMO Part C Days Medicare Fraction 2<sup>nd</sup> Group
- 18-0516G BRI Independent Hosps 2011 Medicare HMO Part C Days Medicaid Fraction 2<sup>nd</sup> Group
- 18-0582G BRI Independent Hosps 2010 Medicare HMO Part C Days Medicare Fraction Group
- 18-0583G BRI Independent Hosps 2010 Medicare HMO Part C Days Medicaid Fraction Group

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 1, 2019 request for expedited judicial review ("EJR") (received April 4, 2019), for the above-referenced appeals. The Board's determination is set forth below.

**Issue in Dispute**

The issue in these appeals is:

Whether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).<sup>1</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

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<sup>1</sup> Providers' EJR request at 1.

prospective payment system ("PPS").<sup>2</sup> Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.<sup>3</sup>

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .  
(emphasis added)

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.<sup>9</sup>

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

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<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> 42 C.F.R. § 412.106(b)(2)-(3).

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. (emphasis added)

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.<sup>10</sup>

### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>11</sup> stated that:

Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].<sup>12</sup>

<sup>10</sup> 42 C.F.R. § 412.106(b)(4).

<sup>11</sup> of Health and Human Services.

<sup>12</sup> 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>13</sup>

With the creation of Medicare Part C in 1997,<sup>14</sup> Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.<sup>15</sup>

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

... once a beneficiary has elected to join an M+C plan, that beneficiary’s benefits are no longer administered under Part A  
... once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient’s days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . (emphasis added)<sup>16</sup>

The Secretary purportedly changed her position in the Federal fiscal year (“FFY”) 2005 IPPS final rule, by noting she was “revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation.”<sup>17</sup> In response to a comment regarding this change, the Secretary explained that:

... We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the

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<sup>13</sup> *Id.*

<sup>14</sup> The Medicare Part C program did not begin operating until January 1, 1999. See P.L. 105-33, 1997 HR 2015, codified as 42 U.S.C. § 1394w-21 Note (c) “Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . .” This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

<sup>15</sup> 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

<sup>16</sup> 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

<sup>17</sup> 69 Fed. Reg. at 49,099.

Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction.* We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.<sup>18</sup> (emphasis added)

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.<sup>19</sup> In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).<sup>20</sup> As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) “to clarify” the Part C DSH policy by replacing the word “or” with “including.”<sup>21</sup>

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,<sup>22</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.<sup>23</sup> However, the Secretary has not acquiesced to that decision.

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<sup>18</sup> *Id.*

<sup>19</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>20</sup> 72 Fed. Reg. at 47411.

<sup>21</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>22</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>23</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the

More recently, in *Allina Health Services v. Price* (“*Allina II*”),<sup>24</sup> the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>25</sup> The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>26</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers’ Request for EJR**

The Providers assert that EJR is appropriate because the Secretary has not acquiesced to the decision in *Allina I*. As a result, the 2004 rulemaking requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effective as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). The Providers point out that they have met the timely filing requirements and the amount in controversy and believe that EJR is appropriate since the Board is bound by the regulation.

### **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.

### **Jurisdictional Determination**

The participants in this EJR request have filed an appeals involving fiscal years 2006, 2010 and 2011.

For purposes of Board jurisdiction over a participant’s appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a “self-disallowed cost,” pursuant to the Supreme Court’s reasoning set out in *Bethesda Hospital Association v. Bowen* (“*Bethesda*”).<sup>27</sup> In that case, the Supreme Court concluded that a cost

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Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>24</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>25</sup> *Id.* at 943.

<sup>26</sup> *Id.* at 943-945.

<sup>27</sup> 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.).

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.<sup>28</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>29</sup> 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*").<sup>30</sup> 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.<sup>31</sup>

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on or after 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.

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>32</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that jurisdiction over the participants involved with the instant EJR request is governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. The appeals of revised NPRs have adjustments to the Part C issue as required by 42 C.F.R. § 405.1889. In addition, the participants' documentation shows that the estimated amount in controversy

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<sup>28</sup> *Bethesda* at 1258-59.

<sup>29</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>30</sup> 201 F. Supp. 3d 131 (D.D.C. 2016)

<sup>31</sup> *Banner* at 142.

<sup>32</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).



exceeds \$50,000, as required for a group appeal<sup>33</sup> and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJRs involve the 2006, 2010 and 2011 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>34</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>35</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the Providers are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and

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<sup>33</sup> See 42 C.F.R. § 405.1837.

<sup>34</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016).

<sup>35</sup> See 42 U.S.C. § 1395oo(f)(1).

hereby grants the Providers' requests for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since there are no other issues under dispute in these cases, the cases are hereby closed.

Board Members Participating:

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

FOR THE BOARD:

4/23/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Pam VanArsdale (Electronic Mail w/ Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

James Ravindran, President  
Quality Reimbursement Services  
150 N. Santa Anita Avenue  
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Arcadia, CA 91006

**RE: EJ R Determination**

15-2921GC – QRS/Houston Methodist 2010 DSH Medicaid Fraction Medicare Mngd Care Part C Days  
15-2924GC – QRS/Houston Methodist 2011 DSH SSI Fraction Medicare Managed Care Part C Days  
15-2928GC – QRS/Houston Methodist 2011 DSH Medicaid Fraction Medicare Mngd Care Part C Days  
16-0440GC – QRS/Houston Methodist 2012 DSH SSI Fraction Medicare Managed Care Part C Days  
16-0448GC – QRS/Houston Methodist 2011 DSH Medicaid Fraction Medicare Mngd Care Part C Days  
15-2942GC – QRS/TMH Post 10/1/2004, 2005-2006 Medicare Mngd Care Medicaid Eligible Days

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ April 1, 2019 request for expedited judicial review (“EJR”) for the appeals referenced above.<sup>1</sup> The Board’s determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

[W]hether Medicare Advantage Days (“Part C Days”) should be removed from the disproportionate share hospital adjustment (“DSH Adjustment”) Medicare fraction and added to the Medicaid Fraction.<sup>2</sup>

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<sup>1</sup> The request for EJR also included case number 17-0037GC. A decision in that case will be issued in separate correspondence.

<sup>2</sup> Providers’ EJR request at 1.

### Statutory and Regulatory Background: Medicare DSH Payment

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>7</sup> 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.<sup>8</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>9</sup> 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 . . . .<sup>10</sup>

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.<sup>11</sup>

<sup>3</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>4</sup> *Id.*

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>6</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>8</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>9</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>10</sup> (Emphasis added.)

<sup>11</sup> 42 C.F.R. § 412.106(b)(2)-(3).

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

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

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.<sup>13</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>14</sup> stated that:

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

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<sup>12</sup> (Emphasis added.)

<sup>13</sup> 42 C.F.R. § 412.106(b)(4).

<sup>14</sup> of Health and Human Services.

Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].<sup>15</sup>

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>16</sup>

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

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

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

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

<sup>15</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>16</sup> *Id.*

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

<sup>18</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>19</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>20</sup> 69 Fed. Reg. at 49099.

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

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.<sup>22</sup> In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).<sup>23</sup> As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) “to clarify” the Part C DSH policy by replacing the word “or” with “including.”<sup>24</sup>

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,<sup>25</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy

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<sup>21</sup> *Id.* (emphasis added).

<sup>22</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>23</sup> 72 Fed. Reg. at 47411.

<sup>24</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). See also 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

adopted in FFY 2005 IPPS rule.<sup>26</sup> However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* (“*Allina II*”),<sup>27</sup> the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>28</sup> The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>29</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers’ Request for EJR**

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

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

### **Decision of the Board**

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

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<sup>26</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>27</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>28</sup> *Id.* at 943.

<sup>29</sup> *Id.* at 943-945.

<sup>30</sup> Providers’ EJR Request at 1.



## Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 10/1/2004, 2005-2006, 2010, 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 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*").<sup>31</sup> 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.<sup>32</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>33</sup> 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*").<sup>34</sup> 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.<sup>35</sup>

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

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<sup>31</sup> 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.).

<sup>32</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>33</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>34</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>35</sup> *Id.* at 142.

However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

**A. Jurisdictional Determination on Certain Individual Providers in Case No. 15-2942GC**

In Case No. 15-2942GC (entitled QRS/TMH Post 10/1/2004, 2005-2006 Medicare Managed Care Medicaid Eligible Days Group), the Board determined that it lacked jurisdiction over two providers as explained below:

**1. #7 Methodist Willowbrook Hospital (Provider No. 45-0844) for FYE 12/31/2005**

The request for hearing (“RFH”) submitted by #7 Methodist Willowbrook Hospital (“Willowbrook”) on November 7, 2007 for its FY 12/31/2005 included the following four issues: (1) whether the adjustments for operating disproportionate share were correct; (2) whether the adjustments for operating disproportionate share were correct; (3) whether the adjustments for direct medical education were correct; and (4) whether the adjustment to inpatient and outpatient bad debts were correct. However, the RFH does not include the Part C Days issue as part of its appeal for FYE 12/31/2005.<sup>36</sup>

Willowbrook filed its RFH prior to the implementation of the August 21, 2008 revisions to the Board’s governing regulations.<sup>37</sup> As a result of the 2008 revisions, 42 C.F.R. § 405.1835(b) requires that the initial RFH contain a more detailed description of the issues under dispute than the regulations it replaced. To that end, the Board revised its rules<sup>38</sup> to require a concise description of the issues under dispute (Rule 7 (2008)). Further, the Board specifically noted in Rule 8<sup>39</sup> that some issues have multiple components and, to comply with the regulatory requirements, providers must separately identify the items in dispute, appealing the components of an issue separately. The Rule gave the DSH adjustment as a specific example of an issue with multiple components. The May 23, 2008 Federal Register, announcing the effective date of the revised regulations, stated that for appeals pending before the effective date of the regulation providers would have *60 days* after the effective date of the

<sup>36</sup> In contrast, the Board notes that Willowbrook is participating in this group *for other fiscal years* as Participant ##4 and 11 and did specifically appeal or properly add the Part C Days issues for these other fiscal years.

<sup>37</sup> See 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

<sup>38</sup> The Board Rules can be found on the internet at [https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-42 C.F.R. § 405.1835\(e\) \(2008\)Instructions.html](https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-42 C.F.R. § 405.1835(e) (2008)Instructions.html).

<sup>39</sup> Board Rules 8.1 and 8.2 (2008) state:

**8.1 – General**

Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. See common examples below.

**8.2 - Disproportionate Share Cases (e.g., dual eligible, general assistance, charity care, HMO days, etc.)**

regulation to add issues (*i.e.* until October 21, 2008 to add issues).<sup>40</sup> Willowbrook did not add the Part C Days issue, a specific component of the DSH issue, to its individual appeal for FYE 12/31/2005 by the October 21, 2008 deadline as required. Similarly, as the Part C Days issue was neither appealed nor properly added to Willowbrook's individual appeal for FYE 12/31/2005, the transfer request dated February 1, 2011 (but sent March 14, 2011) attempting to transfer that issue from Willowbrook's individual appeal for FYE 12/31/2005 to Case No. 15-2942GC is not valid.

Based on the above, the Board hereby dismisses Willowbrook's FYE 12/31/2005 from Case No. Case No. 15-2942GC because Willowbrook did not appeal the Part C Days issue as required for Board jurisdiction pursuant to 42 C.F.R. § 405.1835(b) (2008) and Board Rules 7 and 8 (2008). Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, Willowbrook's request for EJR as it pertains to FYE 12/31/2005 is denied.<sup>41</sup>

2. # 9 San Jacinto Methodist Hospital (Provider No. 45-0424) for FYE 12/31/2006

The RFH submitted by #9 San Jacinto Methodist Hospital ("San Jacinto") for its FYE 12/31/2006 on November 2, 2009 included the following seven issues: (1) whether operating IME was calculated correctly; (2) whether DME was calculated correctly; (3) *whether operating DSH was determined correctly (the FI included only Medicaid paid pays in determining the numerator of the Medicaid percentage portion of the DSH calculation). The Provider disagreed with the calculation of the second computation of the [DSH adjustment] set forth at 42 C.F.R. §412.106(b)(4). The Provider alleges that the Intermediary failed to include patients eligible for Medicaid, as well as patients eligible for general assistance days;* (5) whether capital IME and DSH were calculated correctly; (6) whether LIP was calculated correctly; (7) whether the rehab ED amount was calculated correctly.

As San Jacinto's NPR was issued after the August 21, 2008 revisions to the Board regulations (as discussed above), it is subject to those revisions and the Board Rules implementing those revisions. In this regard, the Board notes that Board Rule 8 requires that each component of an issue be appealed as a separate issue. However, San Jacinto did not include the Part C Days issue in its RFH for FYE 12/31/2006 as required by Board Rule 8.<sup>42</sup> Further, pursuant to 42 C.F.R. § 405.1835(e) (2008), the Provider had 240 days after the issuance of the NPR to add issues to its appeal. Specifically, the regulation, 42 C.F.R. § 405.1835(e) (2008) states that:

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<sup>40</sup> Fed. Reg. 30,240.

<sup>41</sup> See 42 C.F.R. § 405.1842(a).

<sup>42</sup> In contrast, the Board notes that San Jacinto is participating in this group *for other fiscal years* as Participant ##2 and 6 and did specifically appeal the Part C Days issues for these other fiscal years.

(e) [ ] After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if—

\* \* \* \* \*

(3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day [appeal period] prescribed in paragraph (a)(3) or paragraph (c)(2), of this section.

However, San Jacinto did not add the Part C Days issue, a specific component of the DSH issue, to its individual appeal within the 240 days required under § 405.1835(e). Similarly, as the Part C Days issue was neither appealed nor properly added to San Jacinto's individual appeal for FYE 12/31/2006, the transfer request dated August 15, 2011 attempting to transfer that issue from San Jacinto's individual appeal for FYE 12/31/2006 to Case No. 15-2942GC is not valid.

The Board hereby dismisses San Jacinto's FYE 12/31/2006 from Case No. 15-2942GC because San Jacinto did not appeal the Part C Days issue as required for Board jurisdiction pursuant to 42 C.F.R. § 405.1835(b) (2008) and Board Rules 7 and 8 (2008). Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, San Jacinto's request for EJR as it pertains to FYE 12/31/2006 is denied.<sup>43</sup>

### ***B. Jurisdiction over the Remaining Providers***

The Board has determined that the remaining participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>44</sup> The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying remaining providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

### **Board's Analysis Regarding the Appealed Issue**

The appeals in these EJR requests involve the 10/1/2004, 2005-2006, 2010, 2011 and 2012 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS

<sup>43</sup> See 42 C.F.R. § 405.1842(a).

<sup>44</sup> See 42 C.F.R. § 405.1837.

final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>45</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>46</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It does not have jurisdiction to hear the appeals for Participant ##7 and 9, as set out above, thus these participants are dismissed from their respective group appeals and from this EJR Determination;
- 2) It has jurisdiction over the matter for the subject years and that the remaining participants in these group appeals are entitled to a hearing before the Board;
- 3) Based upon the remaining participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 4) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 5) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSII policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the remaining Providers' request for EJR for the issue and the subject years.

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<sup>45</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>46</sup> See 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

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

For the Board:

4/24/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Bill Tisdale, Novitas (Electronic Mail w/Schedules of Providers)  
Wilson Leong, (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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**Electronic Delivery**

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**RE: *EJR Determination***

14-2184GC Prospect 2009 DSH SSI Part C Days Group  
15-0089GC Prospect 2010 DSH SSI Part C Days Group  
14-4017GC Prospect 2011 DSH SSI Part C Days Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 5, 2019 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

[W]hether the Providers' DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.<sup>1</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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<sup>1</sup> Provider's EJR Request at 1.

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> (Emphasis added.)

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).



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

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.<sup>12</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

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

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

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

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

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

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

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The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,<sup>24</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.<sup>25</sup> However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price (“Allina IP”)*,<sup>26</sup> the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>27</sup> The D.C. Circuit further found in *Allina II* that the

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<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>28</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers' Request for EJR**

The Providers believe that by virtue of the statute, Medicare Part C days should not be included in either the numerator or denominator of the Medicare/SSI fraction. The Providers point out that in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), hospital inpatients who are "entitled to benefits under Part A" are to be included in the Medicare/SSI fraction, with all such patients in the denominator and those who are also entitled to SSI in the numerator. Patients enrolled in a Medicare Part C plan may be "eligible" for Part A, but are not "entitled" to Part A benefits during the months when they have given up their Part A entitlement to enroll in Part C. As a result, the Providers assert, inpatient days associated with these patients do not belong in the Medicare/SSI fraction.

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal because the Providers' appeal was timely filed and the \$50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the 2004 rulemaking for the Part C DSH policy as codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

### **Decision of the Board**

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

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2009, 2010 and 2011.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").<sup>29</sup> In that case, the Supreme Court concluded that a cost

<sup>28</sup> *Id.* at 943-945.

<sup>29</sup> 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

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.<sup>30</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>31</sup> 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*").<sup>32</sup> 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.<sup>33</sup>

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

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>34</sup> The appeals 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 in each case.

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Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.)

<sup>30</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>31</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>32</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>33</sup> *Id.* at 142.

<sup>34</sup> *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2009, 2010 and 2011 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>35</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>36</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years.

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<sup>35</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>36</sup> See 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

Clayton J. Nix, Esq.

Charlotte F. Benson, CPA

Gregory H. Ziegler, CPA, CPC-A

Robert A. Everts, Esq.

Susan A. Turner, Esq.

FOR THE BOARD:

4/24/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Lorraine Frewert, Noridian(Electronic Mail w/Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

Laurence D. Getzoff, Esq.  
Hooper, Lundy and Bookman, P.C.  
1875 Century Park East, Suite 1600  
Los Angeles, CA 90067-2517

**RE: *EJR Determination***

13-1124GC INTEGRIS Health 2008 DSH SSI Part C Days Group  
13-1120GC INTEGRIS Health 2007 DSH SSI Part C Days Group  
14-0828GC INTEGRIS Health 2009 DSH SSI Part C Days Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 5, 2019 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

[W]hether the Providers' DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.<sup>1</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

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

<sup>1</sup> Provider's EJR Request at 1.

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*



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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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*

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<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(I).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> (Emphasis added.)

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

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

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.<sup>12</sup>

#### Medicare Advantage Program

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

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<sup>25</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

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<sup>27</sup> *Id.* at 943.

Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>28</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers' Request for EJR**

The Providers believe that by virtue of the statute, Medicare Part C days should not be included in either the numerator or denominator of the Medicare/SSI fraction. The Providers point out that in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), hospital inpatients who are "entitled to benefits under Part A" are to be included in the Medicare/SSI fraction, with all such patients in the denominator and those who are also entitled to SSI in the numerator. Patients enrolled in a Medicare Part C plan may be "eligible" for Part A, but are not "entitled" to Part A benefits during the months when they have given up their Part A entitlement to enroll in Part C. As a result, the Providers assert, inpatient days associated with these patients do not belong in the Medicare/SSI fraction.

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal because the Providers' appeal was timely filed and the \$50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the 2004 rulemaking for the Part C DSH policy as codified in the 2005 regulation at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

### **Decision of the Board**

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

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2007, 2008 and 2009.

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

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*Association v. Bowen* (“*Bethesda*”).<sup>29</sup> 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.<sup>30</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>31</sup> 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*”).<sup>32</sup> 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.<sup>33</sup>

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant’s appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>34</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

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<sup>29</sup> 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.).

<sup>30</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>31</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>32</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>33</sup> *Id.* at 142.

<sup>34</sup> *See* 42 C.F.R. § 405.1889(b)(1) (2008).

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. The appeals of revised NPRs have adjustments to the Part C Days issue as required by 42 C.F.R. § 405.1889. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>35</sup> The appeals 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 in each case.

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2007, 2008, and 2009 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>36</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>37</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

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<sup>35</sup> See 42 C.F.R. § 405.1837.

<sup>36</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>37</sup> See 42 U.S.C. § 1395oo(f)(1).

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

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

Board Members Participating:

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

FOR THE BOARD:

4/24/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Justin Lattimore, Novitas (Electronic Mail w/Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)





DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board  
1508 Woodlawn Drive, Suite 100  
Baltimore, MD 21207  
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**Electronic Delivery**

Laurence D. Getzoff, Esq.  
Hooper, Lundy and Bookman, P.C.  
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Los Angeles, CA 90067-2517

**RE: *EJR Determination***

14-0222GC Emory University Hospital 2008 DSH SSI Part C Days Group  
14-0570GC Emory University Hospital 2007 DSH SSI Part C Days Group  
14-0553GC Emory University Hospital 2009 DSH SSI Part C Days Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 5, 2019 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

[W]hether the Providers' DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.<sup>1</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

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

<sup>1</sup> Provider's EJR Request at 1.

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> (Emphasis added.)

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

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

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.<sup>12</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

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<sup>11</sup> (Emphasis added.)

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

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

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

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

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

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

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

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,<sup>24</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.<sup>25</sup> However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price (“Allina II”)*,<sup>26</sup> the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>27</sup> The D.C. Circuit further found in *Allina II* that the

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<sup>20</sup> *Id.* (emphasis added).

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> 72 Fed. Reg. at 47411.

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The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal because the Providers' appeal was timely filed and the \$50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the 2004 rulemaking for the Part C DSH policy as codified in the regulations at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

### **Decision of the Board**

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

### **Jurisdiction**

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<sup>34</sup> *See* 42 C.F.R. § 405.1889(b)(1) (2008).

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. The appeals of revised NPRs have adjustments to the Part C Days issue as required by 42 C.F.R. § 405.1889. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>35</sup> The appeals 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 in each case.

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2007, 2008, and 2009 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPSS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPSS final rule (with a minor revision published in the FFY 2011 IPSS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>36</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>37</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

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<sup>35</sup> See 42 C.F.R. § 405.1837.

<sup>36</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>37</sup> See 42 U.S.C. § 1395oo(f)(1).



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

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

Board Members Participating:

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

FOR THE BOARD:

4/24/2019

**X** Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Cecile Huggins, Palmetto GBA (Electronic Mail w/Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

Laurence D. Getzoff, Esq.  
Hooper, Lundy and Bookman, P.C.  
1875 Century Park East, Suite 1600  
Los Angeles, CA 90067-2517

**RE: EJR Determination**

13-0364GC Community Medical Centers 2007 DSH SSI Part C Days Group  
13-2742GC Community Medical Centers 2008 DSH SSI Part C Days Group  
13-3769GC Community Medical Centers 2009 DSH SSI Part C Days Group  
14-2340GC Community Medical Centers 2010 DSH SSI Part C Days Group  
15-2228GC Community Medical Centers 2011 DSH SSI Part C Days Group  
15-2413GC CMC 2012 DSH SSI Part C Days Group  
16-1393GC CMC 2013 DSH SSI Part C Days Group

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 9, 2019 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

[W]hether the Providers' DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.<sup>1</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

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

<sup>1</sup> Provider's EJR Request at 1.

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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.<sup>11</sup>

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<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(I).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> (Emphasis added.)

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

<sup>11</sup> (Emphasis added.)

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

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

With the creation of Medicare Part C in 1997,<sup>16</sup> Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

<sup>16</sup> The Medicare Part C program did not begin operating until January 1, 1999. See P.L. 105-33, 1997 HR 2015, codified as 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.<sup>17</sup>

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

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

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

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

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

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.<sup>20</sup>

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.<sup>21</sup> In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R.

§§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).<sup>22</sup> As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) “to clarify” the Part C DSH policy by replacing the word “or” with “including.”<sup>23</sup>

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

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<sup>20</sup> *Id.* (emphasis added).

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> 72 Fed. Reg. at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

<sup>28</sup> *Id.* at 943-945.

### **Providers' Request for EJR**

The Providers believe that by virtue of the statute, Medicare Part C days should not be included in either the numerator or denominator of the Medicare/SSI fraction. The Providers point out that in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), hospital inpatients who are "entitled to benefits under Part A" are to be included in the Medicare/SSI fraction, with all such patients in the denominator and those who are also entitled to SSI in the numerator. Patients enrolled in a Medicare Part C plan may be "eligible" for Part A, but are not "entitled" to Part A benefits during the months when they have given up their Part A entitlement to enroll in Part C. As a result, the Providers assert, inpatient days associated with these patients do not belong in the Medicare/SSI fraction.

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal because the Providers' appeal was timely filed and the \$50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the 2004 rule for the Medicare Part C DSH policy as codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

### **Decision of the Board**

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

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2007-2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").<sup>29</sup> 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

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<sup>29</sup> 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.<sup>30</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>31</sup> 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*”).<sup>32</sup> 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.<sup>33</sup>

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant’s appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>34</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. The appeals of revised NPRs have adjustments to the Part C Days issue as required by 42 C.F.R. § 405.1889. In addition, the participants’ documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>35</sup> The appeals 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 in each case.

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<sup>30</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>31</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>32</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>33</sup> *Id.* at 142.

<sup>34</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

<sup>35</sup> See 42 C.F.R. § 405.1837.



### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2007-2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>36</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>37</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years.

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<sup>36</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>37</sup> See 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

Clayton J. Nix, Esq.

Charlotte F. Benson, CPA

Gregory H. Ziegler, CPA, CPC-A

Robert A. Everts, Esq.

Susan A. Turner, Esq.

FOR THE BOARD:

4/24/2019

 Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Lorraine Frewert, Noridian Health Care Solutions c/o Cahaba Safeguard  
Administrators (Electronic Mail w/Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)



**Electronic Delivery**

James Ravindran  
Quality Reimbursement Services, Inc.  
150 N. Santa Anita Avenue, Suite 570A  
Arcadia, CA 91006

**RE: *EJR Determination***

13-3822GC, QRS VCHS 2008 DSH Medicaid Fraction Medicare Managed Care Part C Days  
13-3823GC, QRS VCHS 2008 DSH SSI Fraction Medicare Managed Care Part C Days  
14-0635GC, QRS VCHS 2009 DSH SSI Fraction Medicare Managed Care Part C Days  
14-0636GC, QRS VCHS 2009 DSH Medicaid Fraction Medicare Managed Care Part C Days  
15-1393GC, QRS VCH 2010 DSH SSI Fraction Medicare Managed Care Part C Days  
15-1395GC, QRS VCH 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days  
15-2329GC, QRS VCH 2011 DSH SSI Fraction Medicare Managed Care Part C Days  
15-2330GC, QRS VCH2011 DSH Medicaid Fraction Medicare Managed Care Part C Days  
16-1473GC, QRS VCH 2013 DSH SSI Fraction Medicare Managed Care Part C Days  
16-1474GC, QRS VCH 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“PRRB” or “Board”) has reviewed the Providers’ April 5, 2019 request for expedited judicial review (“EJR”) of the above-referenced appeals. The Board’s jurisdictional determination and decision regarding the EJR request is set forth below.

**Issue in Dispute**

The issue in these appeals is:

[W]hether “enrollees in Medicare Part C are ‘entitled to benefits’ under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction, or whether, if not regarded as ‘entitled to benefits under Part A,’ they should instead be included in the Medicaid fraction” of the DSH adjustment.<sup>1</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

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<sup>1</sup> Providers’ EJR request at 10.

prospective payment system ("PPS").<sup>2</sup> Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.<sup>3</sup>

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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*

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> Emphasis added.

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

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

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.<sup>12</sup>

### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

With the creation of Medicare Part C in 1997,<sup>16</sup> Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

<sup>11</sup> Emphasis added.

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

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

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.<sup>17</sup>

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

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

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

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

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173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.

<sup>20</sup> *Id.* (emphasis added).

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

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

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

### **Providers’ Request for EJR**

The Providers explain that “[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> *Id.* at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> *Id.* at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

<sup>28</sup> *Id.* at 943-945.

(b)(2)(iii)(B). (The '2004 Rule') The Board is bound by the 2004 Rule."<sup>29</sup> Accordingly, the Providers contend that the Board should grant their request for EJR.

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

### **Decision of the Board**

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

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2008-2011 and 2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("Bethesda").<sup>30</sup> 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.<sup>31</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>32</sup> 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

<sup>29</sup> Providers' EJR request at 1.

<sup>30</sup> 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.).

<sup>31</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>32</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).



protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* (“*Banner*”).<sup>33</sup> 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.<sup>34</sup>

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

#### Jurisdictional Determination for the Participants

The Board has determined that the participants’ appeals involved with the instant EJR Request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. In addition, the participants’ documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal<sup>35</sup> and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the above-captioned appeals and the remaining participants.

#### Board’s Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2008-2011 and 2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary’s Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (e.g., only circuit-wide versus nationwide).<sup>36</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the

<sup>33</sup> 201 F. Supp. 3d 131 (D.D.C. 2016)

<sup>34</sup> *Id.* at 142.

<sup>35</sup> See 42 C.F.R. § 405.1837.

<sup>36</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff’d*, 875 F.3d 701 (D.C. Cir. 2017).

right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>37</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.<sup>38</sup>

Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPSS final rule are valid.

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

Board Members Participating:

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

For the Board:

4/24/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, [officeofhearings\\_ohcdms@csm.hhs.gov](mailto:officeofhearings_ohcdms@csm.hhs.gov)

<sup>37</sup> See 42 U.S.C. § 1395oo(f)(1).

<sup>38</sup> On April 10, 2019, Wisconsin Physicians Service ("WPS") filed an objection to the instant EJR request. In its filing, WPS argues that the Board should deny the EJR request as the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

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

**RE: *EJR Determination***

14-3265GC QRS Health First 2009 DSH SSI Fraction Medicare Managed Care Part C Days Group  
14-3266GC QRS Health First 2009 DSH Medicare Fraction Medicare Managed Care Part C Days Grp  
16-0588GC QRS Health First 2012 DSH SSI Fraction Medicare Managed Care Part C Days Group  
16-0589GC QRS Health First 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days Grp

Dear Mr. Ravindran :

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 10, 2019 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

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

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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<sup>1</sup> Providers' EJR request at 1.

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . .<sup>9</sup>

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.<sup>10</sup>

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*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(I).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

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

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.<sup>12</sup>

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In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

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<sup>11</sup> (Emphasis added.)

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

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<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

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

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

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

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

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

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

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

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

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

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),<sup>24</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.<sup>25</sup> However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* (“*Allina II*”),<sup>26</sup> the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>27</sup> The D.C. Circuit further found in *Allina II* that the

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Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>28</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers' Request for EJR**

The Providers explain that “[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The ‘2004 Rule’) The Board is bound by the 2004 rule.”<sup>29</sup> Accordingly, the Providers contend that the Board should grant their request for EJR.

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

### **Decision of the Board**

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

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2009 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 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*”).<sup>30</sup> In that case, the Supreme Court concluded that a cost

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<sup>28</sup> *Id.* at 943-945.

<sup>29</sup> Providers’ EJR Request at 1.

<sup>30</sup> 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.).



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.<sup>31</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>32</sup> 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*").<sup>33</sup> 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.<sup>34</sup>

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>35</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. The appeals of revised NPRs have adjustments to the Part C Days issue as required by 42 C.F.R. § 405.1889. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for

<sup>31</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>32</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>33</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>34</sup> *Id.* at 142.

<sup>35</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

a group appeal.<sup>36</sup> The appeals 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 in each case.

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2009 and 2012 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>37</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>38</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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<sup>36</sup> See 42 C.F.R. § 405.1837.

<sup>37</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>38</sup> See 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

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

FOR THE BOARD:

4/30/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Geoff Pike, First Coast Service Options (Electronic Mail w/Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

Michael G. Newell  
Southwest Consulting Associates  
2805 Dallas Parkway  
Suite 620  
Plano, TX 75093-8724

**RE: *EJR Determination***

15-0317GC Conemaugh 2011 DSH SSI Fraction Part C Days Group  
15-0318GC Conemaugh 2011 DSH Medicaid Fraction Part C Days Group  
15-1912GC SWC Einstein 2012 DSH Medicaid Fraction Part C Days Group  
15-1914GC SWC Einstein Health 2012 DSH SSI Fraction Part C Days Group

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 11, 2019 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

[W]hether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator or vice-versa.<sup>1</sup>

**Statutory and Regulatory Background: Medicare DSH Payment**

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

<sup>1</sup> Providers' EJR Request at 4.

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> (Emphasis added.)

<sup>10</sup> 42 C.F.R. § 412.106(b)(2)-(3).

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

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.<sup>12</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

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<sup>11</sup> (Emphasis added.)

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

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

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

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

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

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

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Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>28</sup> Once again, the Secretary has not acquiesced to this decision.

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### **Decision of the Board**

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

### **Jurisdiction**

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

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 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*”).<sup>30</sup> In that case, the Supreme Court concluded that a cost

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<sup>28</sup> *Id.* at 943-945.

<sup>29</sup> Providers’ EJR Request at 1.

<sup>30</sup> 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.).

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.<sup>31</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>32</sup> 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*").<sup>33</sup> 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.<sup>34</sup>

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>35</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. The appeal of the revised NPR contained an adjustment to Part C Days as required for Board jurisdiction. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for

<sup>31</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>32</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>33</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>34</sup> *Id.* at 142.

<sup>35</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

a group appeal.<sup>36</sup> The appeals 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 in each case.

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2011-2012 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>37</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>38</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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<sup>36</sup> See 42 C.F.R. § 405.1837.

<sup>37</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>38</sup> See 42 U.S.C. § 1395oo(f)(1).


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

Board Members Participating:

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

FOR THE BOARD:

4/30/2019

 Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Bruce Snyder, Novitas (Electronic Mail w/Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

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

**RE: *EJR Determination***

14-3269GC QRS/Providence 2006 DSH Medicare Part C Days Group  
15-1295GC QRS/Providence 2010 SSI Fraction Part C Days Group  
15-0937GC QRS/Providence 2011 SSI Part C Group  
15-0927GC QRS/Providence 2012 SSI Part C Group  
15-0934GC QRS/Providence 2012 DSH Medicare Part C Days Group  
16-1132GC QRS/Providence 2013 SSI Fraction Part C Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 3, 2019 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

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

**Statutory and Regulatory Background: Medicare DSH Payment**

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

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<sup>1</sup> Providers' EJR request at 1.

prospective payment system ("PPS").<sup>2</sup> Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.<sup>3</sup>

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>6</sup> 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.<sup>7</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>8</sup> 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 . . . .<sup>9</sup>

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.<sup>10</sup>

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

<sup>2</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>3</sup> *Id.*

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>6</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(I).

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>8</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>9</sup> (Emphasis added.)

<sup>10</sup> 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.<sup>11</sup>

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.<sup>12</sup>

### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>13</sup> stated that:

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>15</sup>

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<sup>11</sup> (Emphasis added.)

<sup>12</sup> 42 C.F.R. § 412.106(b)(4).

<sup>13</sup> of Health and Human Services.

<sup>14</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>15</sup> *Id.*

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

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

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

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

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

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

<sup>17</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>18</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>19</sup> 69 Fed. Reg. at 49099.



is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.<sup>20</sup>

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

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

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

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<sup>20</sup> *Id.* (emphasis added).

<sup>21</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>22</sup> 72 Fed. Reg. at 47411.

<sup>23</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>24</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>26</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>27</sup> *Id.* at 943.

Medicare fractions published for FY 2012.<sup>28</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers' Request for EJR**

The Providers explain that “[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The ‘2004 Rule’) The Board is bound by the 2004 rule.”<sup>29</sup> Accordingly, the Providers contend that the Board should grant their request for EJR.

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

### **Decision of the Board**

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

### **Deficiencies in the Schedule of Providers and Supporting Documentation**

As explained below, the Board reminds the Group Representative to accurately enter the information required by the Board’s rules, furnish complete documentation, and furnish Schedules of Providers in type that is at least 10 point and to leave space between each entry on the Schedule of Providers.

The font that the Group Representative used for the majority of Schedules of Providers is *too small*. For example, when it is scanned as an attachment to the EJR decision, it becomes unreadable. *Accordingly, the Board reminds the Group Representative to furnish Schedules of Providers in type that is at least 10 point and to leave space between each entry on the Schedule of Providers.*

Pursuant to 42 C.F.R. § 405.1801(a)(2), the date of receipt of an appeal is the date of delivery by a next day carrier (FedEx, USPS, UPS, etc.) or the date stamp “received” by the Board. In addition, Board Rule 21.3 requires that for appeals filed after August 21, 2008, the jurisdictional

<sup>28</sup> *Id.* at 943-945.

<sup>29</sup> Providers’ EJR Request at 1.

documents are to include the proof of delivery (*i.e.*, the overnight carriers delivery receipt). For the Schedule of Providers, the Group Representative must: (1) enter in Column B the date the Board received the hearing request based on the carrier's delivery date; and (2) enter the number of days in Column C based on the date of receipt of the hearing request. In these cases, the Group Representative failed to enter the *correct* date that the Board received the hearing request in Column B, as evidenced by the overnight carriers' receipts (in some cases the Medicare Contractor's receipt was included, not the receipt for delivery to the Board). In some cases, the date of receipt was entered did not match either the overnight carriers receipt or the date "received" in the Boards records. Further, where the Group Representative filed a copy of the original group hearing request used to establish the group appeal, in many instances, the Provider did not include the original documentation (usually a preliminary Schedule) to demonstrate that the Provider(s) had been included in the original appeal and, *as a courtesy*, the Board was able to review the original hearing request in the case file to establish the date that the hearing request was stamped as received. ***Accordingly, the Board reminds the Group Representative to ensure that: (1) it accurately enters information in the Schedule of Providers based on the documentation being attached to the Schedule of Providers in support thereto; and (2) it includes the copies of the requisite proof-of-delivery documentation behind the appropriate tab.***

Notwithstanding the above deficiencies, the Board did process the EJR request as a courtesy rather than return them to the Group Representative for correction. If these become a recurring issue with the Group Representative's filings in other cases, the Board may take remedial action such as returning deficient filings for correction and refileing.

### Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006 and 2010-2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").<sup>30</sup> 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.<sup>31</sup>

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<sup>30</sup> 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.).

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On August 21, 2008, new regulations governing the Board were effective.<sup>32</sup> 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*”).<sup>33</sup> 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.<sup>34</sup>

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant’s appeal of matters that the Medicare contractor specifically revised within the revised NPR.<sup>35</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. The appeals of revised NPRs have adjustments to the Part C Days issue as required by 42 C.F.R. § 405.1889 for jurisdiction.

In addition, the participants’ documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>36</sup> ***Notwithstanding the inaccurate summary of the proof-of-delivery information furnished in the Schedule of Providers as discussed above,*** the Board’s review of the supporting proof-of-delivery documentation confirms that the appeals 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 in each case.

<sup>32</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>33</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>34</sup> *Id.* at 142.

<sup>35</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

<sup>36</sup> See 42 C.F.R. § 405.1837.

### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2006 and 2010-2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>37</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>38</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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

<sup>37</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>38</sup> See 42 U.S.C. § 1395oo(f)(1).

Board Members Participating:

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Susan A. Turner, Esq.

FOR THE BOARD:

4/30/2019

X Clayton J. Nix

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Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: John Bloom, Noridian (Electronic Mail w/Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

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

**RE: *EJR Determination***

- 14-1308GC QRS DCH 2007 DSH SSI Fraction Medicare Managed Care Part C Days Group
- 14-1334GC QRS DCH 2007 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
- 14-2383GC QRS DCH 2008 DSH SSI Fraction Medicare Managed Care Part C Days Group
- 14-2386GC QRS DCH 2008 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
- 14-2420GC QRS DCH 2009 Medicaid Fraction Medicare Managed Care Part C Days Group
- 14-2434GC QRS DCH 2009 DSH SSI Fraction Medicare Managed Care Part C Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ April 10, 2019 request for expedited judicial review (“EJR”) for the appeals referenced above.<sup>1</sup> The Board’s determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in these appeals is:

[W]hether Medicare Advantage Days (“Part C Days”) should be removed from the disproportionate share hospital adjustment (“DSH Adjustment”) Medicare fraction and added to the Medicaid Fraction.<sup>2</sup>

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<sup>1</sup> The EJR request also included case number 12-0280GC. A response to the request for EJR in that case will be sent under separate cover.

<sup>2</sup> Providers’ EJR request at 1.

**Statutory and Regulatory Background: Medicare DSH Payment**

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").<sup>7</sup> 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.<sup>8</sup> The DPP is defined as the sum of two fractions expressed as percentages.<sup>9</sup> 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 . . . .<sup>10</sup>

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.<sup>11</sup>

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

<sup>3</sup> See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

<sup>4</sup> *Id.*

<sup>5</sup> See 42 U.S.C. § 1395ww(d)(5).

<sup>6</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

<sup>7</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

<sup>8</sup> See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

<sup>9</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

<sup>10</sup> (Emphasis added.)

<sup>11</sup> 42 C.F.R. § 412.106(b)(2)-(3).



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.<sup>12</sup>

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.<sup>13</sup>

#### Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary<sup>14</sup> stated that:

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

<sup>12</sup> (Emphasis added.)

<sup>13</sup> 42 C.F.R. § 412.106(b)(4).

<sup>14</sup> of Health and Human Services.

including HMO days in the SSI/Medicare percentage [of the DSH adjustment].<sup>15</sup>

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>16</sup>

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

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

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

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

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<sup>15</sup> 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

<sup>16</sup> *Id.*

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

<sup>18</sup> 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

<sup>19</sup> 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

<sup>20</sup> 69 Fed. Reg. at 49099.

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

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.<sup>22</sup> In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).<sup>23</sup> As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) “to clarify” the Part C DSH policy by replacing the word “or” with “including.”<sup>24</sup>

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),<sup>25</sup> vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy

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<sup>21</sup> *Id.* (emphasis added).

<sup>22</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>23</sup> 72 Fed. Reg. at 47411.

<sup>24</sup> 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: “We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word ‘or’ with the word ‘including’ in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B).”); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff’d in part and rev’d in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

<sup>25</sup> 746 F. 3d 1102 (D.C. Cir. 2014).

adopted in FFY 2005 IPPS rule.<sup>26</sup> However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* (“*Allina IP*”),<sup>27</sup> the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.<sup>28</sup> The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.<sup>29</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers’ Request for EJR**

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

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

### **Decision of the Board**

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

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2007, 2008 and 2009.

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<sup>26</sup> 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

<sup>27</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>28</sup> *Id.* at 943.

<sup>29</sup> *Id.* at 943-945.

<sup>30</sup> Providers’ EJR Request at 1.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").<sup>31</sup> 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.<sup>32</sup>

On August 21, 2008, new regulations governing the Board were effective.<sup>33</sup> 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*").<sup>34</sup> 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.<sup>35</sup>

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

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<sup>31</sup> 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.).

<sup>32</sup> *Bethesda*, 108 S. Ct. at 1258-59.

<sup>33</sup> 73 Fed. Reg. 30190, 30240 (May 23, 2008).

<sup>34</sup> 201 F. Supp. 3d 131 (D.D.C. 2016).

<sup>35</sup> *Id.* at 142.

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>36</sup> The appeals 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 in each case.

#### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2007, 2008 and 2009 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).<sup>37</sup> Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.<sup>38</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

#### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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<sup>36</sup> See 42 C.F.R. § 405.1837.

<sup>37</sup> See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

<sup>38</sup> See 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

Clayton J. Nix, Esq.  
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FOR THE BOARD:

4/30/2019

 Clayton J. Nix

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Chair

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