



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board  
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Baltimore, MD 21207  
410-786-2671

**Electronic Mail**

Christopher Keough, Esq.  
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1333 New Hampshire Avenue, NW  
Washington, DC 20036-1564

**RE: Expedited Judicial Review Determination**

13-0199GC	Banner Health 2006 SSI Part C Group
14-1976GC	SCA Covenant Health 2010 Medicaid Part C Days Group
14-1978GC	SCA Covenant Health 2010 DSH SSI Part C Days Group
14-2545GC	SCA Covenant Health 2011 DSH SSI Part C Days Group
14-2546GC	SCA Covenant Health 2011 Medicaid Part C Groups
14-3166GC	SCA SUNY 2010 DSH Medicaid Part C Days Group
14-3171GC	SCA SUNY 2010 DSH SSI Part C Days Group

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' April 11, 2019 request for expedited judicial review (EJR) (received April 12, 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:

Whether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI<sup>1</sup> fraction and excluded from the Medicaid fraction numerator or vice-versa.<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>

<sup>1</sup> "SSI" is the acronym for "Supplemental Security Income."

<sup>2</sup> Providers' EJR Request at 4.

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

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

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 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>

<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).

<sup>12</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>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 care coverage under Medicare Part C were no longer entitled to have payment made for their

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

<sup>14</sup> 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, *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>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:

... 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>

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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>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.

<sup>21</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>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 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 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.

<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.

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 FFY 2005 Final Rule, 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>30</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>31</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 this case, 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 I*, 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 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>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

<sup>30</sup> 69 Fed. Reg. at 49,099.

<sup>31</sup> *Allina* at 1109.

<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.).

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. 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 Notice of Program Reimbursement (NPR).<sup>37</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 Providers which filed appeals of revised NPRs have an adjustment to Part C Days as required. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>38</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.

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<sup>33</sup> *Bethesda* at 1258-59.

<sup>34</sup> 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

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

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

<sup>37</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

<sup>38</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 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>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 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 Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

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<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.  
Susan A. Turner, Esq.

FOR THE BOARD:

5/2/2019

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)  
Cecile Huggins, Palmetto GBA (Electronic Mail w/Schedules of Providers)  
Pam VanArsdale, NGS (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  
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**Electronic Delivery**

James Ravindran, President  
Quality Reimbursement Services  
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Suite 570A  
Arcadia, CA 91006

**RE: *EJR Determination***

Methodist Hospital of Southern California  
Provider No. 05-0238  
FYE 12/31/2005  
Case No. 10-0827

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 11, 2019 request for expedited judicial review ("EJR") for the appeal referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this case 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

<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:

*. . . 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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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 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.

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<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.

### **Provider's Request for EJR**

The Provider explains 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 Provider contends that the Board should grant their request for EJR.

The Provider asserts 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 Provider maintains 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 Provider believes it has 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 participant in this appeal has filed an EJR for fiscal year December 31, 2005.

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>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.

The Board has determined that the participant involved with the instant EJR request is governed by the decision in *Bethesda*. In addition, the participant's documentation shows that the estimated amount in controversy exceeds \$10,000, as required for an individual appeal.<sup>32</sup> The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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

The appeal in this EJR requests involves the 2005 cost 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 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>33</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>34</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 participant in this individual appeal is entitled to a hearing before the Board;
- 2) Based upon the participant's assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(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.

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<sup>32</sup> See 42 C.F.R. § 405.1835(a)(2).

<sup>33</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>34</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 Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this was the sole remaining issue this appeal, the appeal is hereby closed.

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:

5/2/2019

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian  
Wilson Leong, FSS



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Mail**

Christopher Keough, Esq.  
Akin Gump Straus Hauer & Feld LLP  
1333 New Hampshire Avenue, NW  
Washington, DC 20036-1564

**RE: Expedited Judicial Review Determination**

16-0798GC Baptist Health South Florida 2013 DSH SSI Fraction Part C Days Group  
16-0799GC Baptist Health South Florida 2013 DSH Medicaid Fraction Part C Days Group

Dear Mr. Keough:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 12, 2019 request for expedited judicial review ("EJR") (received April 15, 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:

Whether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI<sup>1</sup> fraction and excluded from the Medicaid fraction numerator or vice-versa.<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

<sup>1</sup> "SSI" is the acronym for "Supplemental Security Income."

<sup>2</sup> Providers' EJR Request at 4.

<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).

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 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>

<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)(I).

<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).

<sup>12</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>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 care coverage under Medicare Part C were no longer entitled to have payment made for their

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

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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

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:

... 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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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).

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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 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 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 FFY 2005 IPPS Final Rule, 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>30</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>31</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 this case, 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 I*, 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 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-

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<sup>30</sup> 69 Fed. Reg. at 49,099.

<sup>31</sup> *Allina* at 1109.

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. 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> 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

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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* at 1258-59.

<sup>34</sup> 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

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

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

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



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

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

The appeals in this EJR request involve the 2013 cost reporting period. 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>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.<sup>40</sup>

#### 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 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).

<sup>40</sup> On August 3, 2017, 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 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.

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

Board Members Participating:

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

FOR THE BOARD:

5/3/2019

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Provider Reimbursement Review Board  
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**Electronic Delivery**

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**RE: *EJR Determination***

13-1517GC Ascension 2008 DSH Medicare/Medicaid Advantage Days Group  
17-0798G Hall Render 2005 DSH Medicare/Medicaid Advantage Days Group

Dear Ms. Griffin:

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:

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

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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

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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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 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.

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<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 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 and 2008.

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>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.



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 for Certain Individual Participants*

In Case No. 13-1517GC, St. John Hospital (Provider No. 23-0165, FYE 6/30/2008) at Exhibit ## 14.A and B appealed from a revised Notice of Program Reimbursement (NPR) and identified Adjustment No. 6 as the subject of the dispute. Adjustment No. 6 was an adjustment to Medicaid days and the DSH percentage. From the review of the documentation, there was no evidence that Part C days were revised as required for Board jurisdiction under 42 C.F.R. § 405.1889 for Board jurisdiction.

Similarly, in the same case, Brackenridge Hospital (Provider No. 45-0124, FYE 6/30/2008) at Exhibit ## 22.A and B appealed a revised NPR and identified Adjustment Nos. 4 and 5 as the subject of the dispute. Adjustment Nos. 4 and 5 adjusted Medicaid days and the DSH percentage. From the review of the documentation, there was no

<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).

evidence that Part C days were revised as required for Board jurisdiction under 42 C.F.R. § 405.1889 for Board jurisdiction.

Based on the above, the Board concludes that it lacks jurisdiction over the revised NPR appeals for St. John Hospital (Provider No. 23-0165, FYE 6/30/2008) at Exhibit ## 14.A and B and Brackenridge Hospital (Provider No. 45-0124, FYE 6/30/2008) at Exhibit ## 22.A and B. Accordingly, the Board hereby dismisses the revised NPR appeals for St. John Hospital (Provider No. 23-0165, FYE 6/30/2008) at Exhibit ## 14.A and B and Brackenridge Hospital (Provider No. 45-0124, FYE 6/30/2008) at Exhibit ## 22.A and B from Case No. 13-1517GC. As jurisdiction over a provider is a prerequisite to granting a request for EJR,<sup>36</sup> the Board denies St. John Hospital and Brackenridge Hospital's requests for EJR based on the appeal of their respective revised NPRs for FYE 6/30/2008.

The Board notes that both of these Providers have valid appeals from their original NPRs for FYE 6/30/2008 in Case No. 13-1517GC — Exhibit ##13.A and B for St. John Hospital and ##21.A and B for Backenridge Hospital.

#### *B. Jurisdiction and EJR for the Remaining Participants*

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. The appeal of the revised NPR contained an adjustment to Part C Days as required for Board jurisdiction. In addition, the remaining 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 participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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

The appeals in these EJR requests involve the 2005 and 2008 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>38</sup> Moreover, the D.C. Circuit is the only circuit to date that has

<sup>36</sup> See 42 C.F.R. § 405.1842(a).

<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).

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.<sup>40</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 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 remaining 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. Evarts, Esq.  
Susan A. Turner, Esq.

For the Board:

5/3/2019

X Clayton J. Nix

Clayton J. Nix, Esq.  
Chair

Signed by: Clayton J. Nix -A

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

<sup>40</sup> On August 3, 2017, 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 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.

Hall Render Ascension/Independent Medicare Part C Days Groups

PRRB Case Nos. 13-1517GC, 17-0798G

Page 10

Enclosures: Schedules of Providers

cc: Bryron 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  
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**Electronic Delivery**

Del Nord  
Quality Reimbursement Services  
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**RE: *EJR Determination***

15-0566GC QRS UW 2010 Part C Days Group  
15-0565GC QRS UW 2008-2009 Part C Days Group

Dear Mr. Nord:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 12, 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>

<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)(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.

<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.

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 2008-2010.

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

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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.

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>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>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. § 405.1837.

### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2008-2010 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>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. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

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<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).

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:

5/3/2019

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)

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

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**Electronic Delivery**

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

**RE: *EJR Determination***

15-0605GC HRS Prime Health 2012 DSH SSI Fraction Medicare Mngd Care Part C Days  
15-0606GC HRS Prime Health 2012 DSH Medicaid Fraction Medicare Mngd Care Part C Days  
17-0735G HRS 2006 DSH SSI Fraction Medicare Managed Care Part C Days Group  
16-0737G HRS 2006 DSH Medicaid Fraction Medicare Managed Care Part C Days Group  
17-1886G HRS 2012 DSH SSI Fraction Medicare Managed Care Part C Days Group  
17-1887G HRS 2006 DSH Medicaid Fraction Medicare Managed Care Part C Days Group

Dear Ms. Goron:

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 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:

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)(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 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>

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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).

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 because 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

<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.

(b)(2)(iii)(B) (the 2004 Rule). The Board is bound by the 2004 rule and the Providers and 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 and Previously-Withdrawn Providers on Schedule of Providers**

The Board notes that, contrary to the Board’s regulations and rules, the Group Representative *improperly included previously-dismissed and previously-withdrawn providers on the Schedule of Providers* submitted with the EJR request on April 5, 2009.

Specifically, Group Representative *improperly include* on the Schedules of Providers in Case Nos. 15-0605GC and 15-0606GC the following provider that the Board previously had dismissed on March 10, 2015: #20A Roxborough Memorial Hospital (Provider No. 39-0304) for FYE 12/31/2012. In this regard, as part of the March 10, 2015 dismissal, the Board concluded that it lacked jurisdiction over the appeal of Roxborough Memorial Hospital (including but not limited to the DSH Part C Days issue) in Case No. 15-0871 because the provider did not include a copy of the relevant cost report with its appeal under 405.1835(a)(3)(ii) as required under 42 C.F.R. § 405.1835(b) and Board Rules. Similarly, shortly thereafter, on July 27, 2015, the Board denied the Provider’s request to transfer the DSH Part C Days issue to Case Nos. 15-0605GC and 15-0606GC because the Provider has previously been dismissed on March 10, 2015. Notwithstanding the Provider Representative’s *improper attempt* to include the Provider’s appeal from its failure to receive a timely NPR on the Schedule of Providers, this Provider/determination is not *currently* a participant in Case Nos. 15-0605GC and 15-0606GC. As a result, the #20A Roxborough Memorial Hospital’s request for EJR is hereby denied. Notwithstanding, the Board notes that the appeal for #20B Roxborough Memorial Hospital from the issuance of the *original* Notice of Program Reimbursement (“NPR”) involving FYE 12/31/2012 will remain pending before the Board in both 15-0605GC and 15-0606GC.

Similarly, the Board notes that the Group Representative submitted Schedules of Providers submitted in Case Nos. 15-0605GC and 15-0606GC on April 5, 2019 which *improperly include* the following provider that the Group Representative had previously withdrawn: #21 Pampa

Regional Medical Center (Provider No. 45-0099) for FYE 5/31/2012. On April 15, 2015, the HRS withdrew Pampa Regional Medical Center from both Case Nos. 15-0605GC and 15-0606GC and stated that the Group Representative “*will remove* Pampa Regional Medical Center from the Schedule of Providers when submitted [to the Board].”<sup>29</sup> Notwithstanding the Provider Representative’s *failure to remove* the withdrawn provider from the Schedules of Providers for Case Nos. 15-0605GC and 15-0606GC, this Provider/determination is not *currently* a participant in Case Nos. 15-0605GC and 15-0606GC. As a result, #21 Regional Medical Center’s request for EJR is hereby denied.

#### Jurisdiction Over the Providers Currently in the Group Appeals

The participants that *currently* comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006 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-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>

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<sup>29</sup> Note that the Board does not issue acknowledgement of withdrawals where it does not close a case. See Board Rule 48.

<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.

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 currently 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> 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 2006 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>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) The following providers were either previously dismissed or previously withdrawn and, as such, are not currently part of Case Nos. 15-0605GC and 15-0606GC and cannot be considered in the EJR request for Case Nos. 15-0605GC and 15-0606GC: #20A

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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).

Roxborough Memorial Hospital (Provider No. 39-0304) for FYE 12/31/2012 and #21  
Pampa Regional Medical Center (Provider No. 45-0099) for FYE 5/31/2012;

- 2) It has jurisdiction over the matter for the subject years and that the current participants in the above-captioned 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) (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 in the above-captioned group appeals. 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 II. Ziegler, CPA, CPC-A  
Robert A. Everts, Esq.  
Susan A. Turner, Esq.

FOR THE BOARD:

5/6/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Lorraine Frewert, Noridian (JE) (Electronic Mail w/Schedules of Providers)  
Pam VanArsdale, NGS (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  
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410-786-2671

**Electronic Delivery**

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

**RE: *EJR Determination***

12-0280G QRS DCH 2009 DSH Managed Care Part C Days

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>

**Jurisdiction over Appeals and EJR**

The two participants in Case No. 12-0280GC filed appeals involving the fiscal year (“FY”) 2009 and the Group Representative submitted a request for EJR for Case No. 12-0280GC. The Board notes that 42 C.F.R. § 405.1842, requires that the Board determine whether it has jurisdiction prior to granting an EJR request. Further, the Board is empowered to request “all of the information and documentations [ ] necessary [ ] for issuing” an EJR decision including

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<sup>1</sup> The EJR request also included case number 14-1308GC, 14-1334GC, 14-2383GC, 14-2386GC, 14-2420GC, and 14-2434GC. A response to the request for EJR in those cases will be sent under separate cover.

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

documentation related to jurisdiction.<sup>3</sup> To this end, Board Rule 20<sup>4</sup> requires the group representative to submit a Schedule of Providers and supporting jurisdictional documentation within 60 days of the full formation of the group. Similarly, the Board specified in its acknowledgement of the group appeal request for Case No. 12-0280GC that: “*Upon full formation of the group appeal you must so advise the Board in writing.*”<sup>5</sup>

The Group Representative initiated this group appeal by filing the original group appeal hearing request on *March 23, 2012*. The hearing request established this group appeal by transferring the following two provider from individual appeals that were based the Medicare contractor’s failure to timely issue a final determination within 12 months of the submission of a perfected cost report pursuant to 42 C.F.R. § 405.1835(a)(3)(ii) (2009):

1. DCH Regional Medical Center (“DCH Regional”), Provider No. 01-0092, FYE 9/30/2009
2. Northport Medical Center (“Northport”), Provider No. 01-0145, FYE 9/30/2009

Since filing the appeal on March 23, 2012, the Group Representative has taken no action in the case other than submitting the EJRs request roughly seven years later on April 10, 2019. In particular, the Group Representative has not added any additional providers, has not specifically notified the Board that the group was complete, and has not filed a complete Schedule of Providers with the requisite supporting jurisdictional documentation for the group appeal.

The Board is also aware that both DCH Regional and Northport *later* did receive their original NPR for FYE 9/30/2009 and that they both filed *new* individual appeals based on that original NPR for FYE 9/30/2009. In each of these new appeals, they included the DSH Part C Days issue but they did not seek to transfer and consolidate this issue with the above-captioned group appeal. Rather, they each transferred the DSH Part C Days issue from the new appeals to other group appeals, namely 14-2434GC (SSI fraction) and 14-2420GC (Medicaid fraction).

Based on the above, the Board finds that the Group Representative both abandoned the above-captioned group case and failed to comply with Board procedures as supported by the facts there has been roughly seven years of inactivity in this case and the Group Representative clearly has failed to fulfill its obligation to timely notify the Board the group appeal was complete and fully formed when the appeal was originally filed roughly 7 years ago on March 23, 2012.

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<sup>3</sup> *Id.* at § 405.1842(e)(2)(ii).

<sup>4</sup> The Board’s Rules can be found on the internet at <https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.html>. The Board notes that, on March 1, 2013, it revised Board Rule 20.1 so that it required the group representative to file a complete set of the Schedule of Providers and supporting jurisdictional documentation with *both* the Board and the Medicare Contractor within 60 days of full formation of the group.

<sup>5</sup> (Emphasis added.)



As explained below, the Board's findings are further supported by the fact that the Group Representative did not comply with Board Rule 42.3 (2018). This Rule addresses the content of EJR requests and specifies that: "For a group appeal, the schedule of providers and supporting jurisdictional documents for each provider must . . . be filed in accordance with Rules 20 and 21." In this regard, the Board notes that the Group Representative did not file a complete Schedule of Providers with the EJR request in accordance with the requirements of Board Rule 20.1 (2009) and instead relies on the original Schedule of Providers that was filed with the group appeal request on August 23, 2012.

Notwithstanding this noncompliance, the Board did review the original Schedule of Providers. However, as explained below, the original Schedule of Providers is also not compliant with Board Rules.

As previously mentioned, DCH Regional and Northport base their participation in the above-captioned appeal on individuals appeals under 42 C.F.R. § 1835(a)(3)(ii) (2009) due to the failure of the Medicare contractor to timely issue a final determination for their fiscal year 2009 cost reporting period. In order to ensure compliance with § 405.1835(a)(3)(ii), Board Rule 21.1 requires that the Providers which file appeals of the Medicare contractors failure to timely issue an NPR submit a Schedule of Providers that includes:

- evidence of the Medicare contractor's receipt of the as-filed or amended cost report under appeal, and
- evidence of the Medicare contractor's acceptance of the as-filed or amended cost report under appeal. (See Rule 7.5.)

The Board notes that, as part of the original Schedule of Providers: (1) DCH Regional furnished a cost report certification page without the date of the Medicare Contractor's receipt of the cost report but with an electronic filing date filled in February 24, 2011 and a handwritten signature dated February 26, 2011; and (2) Northport submitted an unsigned Form CMS-2552-96 which indicated the cost report was "received" on March 1, 2010. Further, the hearing request states the following regarding the timeliness of each provider's appeal from the non-issuance of a final determination:

In the present case, the intermediary received the provider's cost report on 3/1/2010. The period for issuance of the NPR by the intermediary expired 12 months later on 3/1/2011. As such, the 180 day period for filing this appeal commenced on 8/28/2011.

However, without the complete and final Schedule of Providers, the remaining requisite jurisdictional documentation (including, but not limited to, the acceptance of the cost report and evidence of the receipt of the cost report) was not available of Board review to enable it to determine whether the Board has jurisdiction over the Providers based on their appeals under § 405.1835(a)(3)(ii).

Base on the above findings, the Board hereby dismisses Case No. 12-0280GC and the remaining two providers in that group (*i.e.*, DCH Regional, FYE 9/30/2009, and Northport, FYE 9/30/2009). Since a jurisdictional determination is a prerequisite to granting a request for EJR, the Board denies the Providers' EJR request. This action closes Case No. 12-0280GC.

Notwithstanding the dismissal and closure of Case No. 12-0280GC, the Board notes that both Providers, DCH Regional and Northport, remain participants in Case Nos. 14-2434GC (SSI fraction) and 14-2420GC (Medicaid fraction) *based on their appeals of their original NPR* for FYE 9/30/2009.

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

Board Members Participating:

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

FOR THE BOARD:

5/6/2019

 Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosure: Schedule of Providers

cc: Cecile Huggins, Palmetto GBA  
Wilson Leong, FSS



DEPARTMENT OF HEALTH & HUMAN SERVICES

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**RE: *EJR Determination***

14-3423GC UMC 2008-2009 Medicare Part C Days CIRP Group  
15-2410GC UMC 2011 SSI Medicare Fraction Part C Days CIRP Group  
15-2411GC UMC 2011 Medicaid Fraction Part C Days CIRP Group  
15-1163GC QRS Univ of AZ Health 2012 SSI Fraction Medicare Mngd Care Part C Days  
15-1164GC QRS Univ of AZ Health 2012 Medicaid Fraction Medicare Mngd Care Part C  
16-0990GC QRS UMC 2013 SSI Fraction Part C Days CIRP Group  
16-0991GC QRS UMC 2013 Medicaid Fraction Part C Days CIRP Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 15, 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 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>

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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 is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our*

<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.

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 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 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 2008, 2009, 2011, 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>

<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.



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.

The Board has determined that the participants in the group cases 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 2008, 2009, 2011, 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

<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. § 405.1837.

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 the 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.

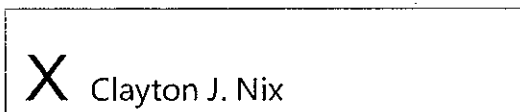
Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' in the appeals request for EJR for the issue and the subject years. The Providers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

For the Board:

5/8/2019

 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)  
Wilson Leong, FSS (Electronic Mail w/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).



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**

16-1867GC MaineHealth 2010 Medicare Fraction HMO Part C Days CIRP Group  
16-1868GC MaineHealth 2010 Medicaid Fraction HMO Part C Days CIRP Group

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 16, 2019 request for expedited judicial review ("EJR") (received April 17, 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 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 . . . .  
(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 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

<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.

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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>

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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>

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>13</sup>

<sup>10</sup> 42 C.F.R. § 412.106(b)(4).

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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>

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... 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 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

<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.

*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. More recently, in *Allina Health Services v. Price* (“*Allina II*”),<sup>24</sup> the D.C. Circuit confirmed that

<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 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).

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 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.

### **Jurisdictional Determination**

The participants in this EJR request have filed appeals involving fiscal year 2010.

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 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>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.).



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.

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 exceeds \$50,000, as required for a group appeal<sup>32</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.

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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. § 405.1837.

### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2010 cost reporting period. 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>33</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>34</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 hereby grants the Providers' request for EJR for the issue and the subject years in the above-captioned group appeals. The Providers have 60 days from the receipt of this decision to

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<sup>33</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>34</sup> See 42 U.S.C. § 1395oo(f)(1).

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.  
Gregory H. Ziegler, CPA, CPC-A  
Robert A. Evarts, Esq.  
Susan A. Turner, Esq.

FOR THE BOARD:

5/8/2019

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**

Maureen O'Brien Griffin, Esq.  
Hall, Render, Killian, Heath & Lyman  
500 North Meridian Street  
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**RE: EJR Determination**

15-1006GC WakeMed 2010 DSH Medicare/Medicaid Fraction Part C Days CIRP Group  
16-1413GC Franciscan Alliance 2012 DSH Part C Days CIRP Group  
16-1934GC WakeMed 2009 DSH Medicare/Medicaid Part C Days CIRP Group  
16-2302GC Franciscan Alliance 2013 DSH Medicare/Medicaid Fraction Part C Days CIRP  
17-2179GC WakeMed 2012 DSH Medicare/Medicaid Fraction Part C Days CIRP Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 15, 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:

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

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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).

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>

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

<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

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

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

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<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.

### **Jurisdiction**

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2009 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>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.

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. 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 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 2009 through 2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the

<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. § 405.1837.

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.<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 the 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 remaining 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

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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).

<sup>38</sup> On April 16, 2019, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in 16-1413Gc and 16-2302GC. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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.  
Gregory H. Ziegler, CPA, CPC-A  
Robert A. Everts, Esq.  
Susan A. Turner, Esq.

FOR THE BOARD:

5/8/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS  
Laurie Polson, Palmetto GBA  
Wilson Leong, FSS



### **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:***

14-4170GC Mercy Health 2011 SSI Fraction Medicare Part C Days CIRP Group  
15-0385GC Mercy Health 2012 SSI Fraction Part C Days CIRP Group  
15-0386GC Mercy Health 2012 Medicaid Fraction Part C Days CIRP Group  
15-3378GC QRS Mercy Health 2013 SSI Fraction Part C Days CIRP Group  
15-3379GC QRS Mercy Health 2013 Medicaid Fraction Part C Days CIRP Group  
17-1128GC QRS Mercy Health 2014 SSI Fraction Part C Days CIRP Group  
17-1130GC Mercy Health System 2014 Medicaid Fraction Part C Days CIRP Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“PRRB” or “Board”) has reviewed the Providers’ April 19, 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*

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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).

*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:

[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*

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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> *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.

Medicare fractions published for FY 2012.<sup>28</sup> Once again, the Secretary has not acquiesced to this decision.

### **Providers' EJR Request**

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 Provider 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 No. 14-4170GC *improperly* includes Mercy Hospital Springfield (Provider No. 26-0065, FYE 6/30/2011) that the Board previously has issued a determination dated March 25, 2015 denying jurisdiction over the Provider and its request to transfer to Case No. 14-4170GC. 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. 14-4170GC and, as such, cannot be considered in this EJR request as it relates to Case No. 14-4170GC. 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.

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

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

### Jurisdiction for the 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 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>

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.

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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.

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 Participants

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. 14-4170GC*: Participant 9 – Mercy Washington, Provider No. 26-0052, FYE 6/30/2011

For Case No. 14-4170GC, the Board finds that it does not have jurisdiction over Participant 9 Mercy Washington because Mercy Washington did not timely file its request to directly appeal into this group from its final determination. Mercy Washington was issued its Notice of Program Reimbursement (“NPR”) on July 7, 2014. According to the USPS Tracking information included at Tab 9B of the Schedule of Providers, the Board received on January 20, 2015 Mercy Washington’s completed “Model Form E Request to Join an Existing Group Appeal: Direct Appeal from Final Determination” to initiate its appeal of the July 7, 2014 final determination. This means the Board received the Model Form E 197 days after Mercy Washington was issued its NPR.

Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and Board rules, an appeal (including a direct appeal to a group from a final determination) must be filed with the Board no later than 180 days after the provider has received its final determination. Specifically, 42 C.F.R. § 405.1835(a)(3) states:

(3) Unless the provider qualifies for a good cause extension[...], the date of the receipt by the Board of the provider’s hearing request must be no later than 180 days after the date of receipt by the Provider of the final contractor or Secretary determination.

For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and Board Rule 4.3, the date of receipt of a NPR is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the

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<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.*”

Board is the date of delivery where the document is transmitted by a nationally-recognized next-day courier or, alternatively, the date stamped “received” by the reviewing entity where a nationally-recognized next-day courier is not used.

Mercy Washington is hereby dismissed from Case No. 14-4170GC because it did not timely file its request to directly appeal to this group from its final determination in accordance with 42 C.F.R. § 405.1835(a)(3) and there was no request for a good cause extension under 42 C.F.R. § 405.1836.

2. *Case Nos. 15-0385GC and 15-0386GC*: Participant 1 – Mercy Medical Center, Provider No. 04-0010, FYE 6/30/2012

For Case Nos. 15-0385GC and 15-0386GC, the Board finds that it does not have jurisdiction over Participant 1 Mercy Medical Center as a participant because Mercy Medical Center did not timely file its requests to directly appeal into these groups from its final determination. Mercy Medical Center was issued its NPR on October 20, 2014. Mercy Medical Center completed and filed the “Model Form E Request to Join an Existing Group Appeal: Direct Appeal from Final Determination” for both Case Nos. 15-0385GC and 15-0386GC. As noted on the Schedule of Providers, the Group Representative “was unable to locate the delivery notification of the Model Form E” for Mercy Medical Center for these two group cases.

As a result, the Board reviewed its files for Case Nos. 15-0385GC and 15-0386GC. Based on the “received” date stamps in the Board’s files,<sup>37</sup> the Board received the Model Form Es for Mercy Medical Center on Friday, April 24, 2015, which is 186 days after its final determination. As the filing was more than 185 days after the date of the final determination (*i.e.*, 180 days plus the 5 days presumed for delivery of the determination), the Board finds that Mercy Medical Center did not timely file its direct-add appeals pursuant to 42 C.F.R. § 405.1835(a)(3). Further, there was no request for a good cause extension under 42 C.F.R. § 405.1836. Accordingly, consistent with its dismissal of Mercy Washington in Case No. 14-4170GC above, the Board hereby dismisses Mercy Medical Center from Case Nos. 15-0385GC and 15-0386GC.

3. *Case Nos. 15-0385GC & 15-0386GC*: Participant 6 – Mercy Hospital Lebanon, Provider No. 26-0059, FYE 6/30/2012

For Case Nos. 15-0385GC and 15-0386GC, the Board finds that it does not have jurisdiction over Participant 6 Mercy Hospital Lebanon (“Mercy Lebanon”) as a participant because Mercy Lebanon did not timely file its requests to directly add its appeal into these groups from its final determination. Mercy Lebanon was issued its

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<sup>37</sup> The Provider’s representative indicated on both Schedules of Providers that it was not able to locate the delivery confirmation for the Model Form E for either group, therefore the Board verified the date it received the forms based on the date stamp “received” in its records. *See* 42 C.F.R. § 405.1801(a)(2).

NPR on June 23, 2014. Mercy Lebanon completed and filed its “Model Form E Requests to Join an Existing Group Appeal: Direct Appeal from Final Determination” for both 15-0385GC and 15-0386GC. Based on the USPS Tracking Data included at Tab 6B, the Board received the Model Form E’s on Wednesday, January 6, 2015, which is 197 days after its final determination. As the filing was more than 185 days after the final determination (*i.e.*, 180 days plus the 5 days presumed for delivery of the determination), the Board finds that Mercy Lebanon did not timely file its direct-add appeals pursuant to 42 C.F.R. § 405.1835(a)(3). Further, there was no request for a good cause extension under 42 C.F.R. § 405.1836. Accordingly, consistent with its dismissal of Mercy Washington in Case No. 14-4170GC above, the Board hereby dismisses Mercy Lebanon from Case Nos. 15-0385GC and 15-0386GC.

4. *Case Nos. 17-1128GC and 17-1130GC*: Participant 3 – Mercy St. Louis, Provider No. 26-0020, FYE 6/30/2014

For Case Nos. 17-1128GC and 17-1130GC, the Board finds that it does not have jurisdiction over Mercy St. Louis because Mercy St. Louis did not include any documentation to establish if or when the Board received its “Model Form E Request to Join an Existing Group Appeal: Direct Appeal from Final Determination” for both Case No. 17-1128GC and Case No. 17-1130GC. Board Rule 21.3.2 states that, if an appeal (or Model Form E) is filed after August 21, 2008, the Provider must “include a copy of the proof of delivery (e.g. USPS, FedEx or UPS tracking).” Mercy St. Louis indicates on the Schedules of Providers in both groups that the Provider Representative “was unable to locate the delivery notification of the Model Form E” and alleges that “[t]he date provided under Tab B is the date the Model Form E was sent to the Board.”<sup>38</sup>

As a result, the Board reviewed its files for Case Nos. 17-1128GC and 17-1130GC. However, the Board did not locate the Model Form E for Mercy St. Louis in either Case No. 17-1128GC or Case No. 17-1130GC, and it does not have a record of receiving them for Mercy St. Louis in either Case No. 17-1128GC or Case No. 17-1130GC. Without proof of delivery, as required by the Board Rules, the Board cannot determine whether Mercy St. Louis ever filed the requisite appeal request forms with the Board and, if so, whether those appeal request forms were in fact timely filed with the Board. Accordingly, the Board finds that it does not have jurisdiction over Mercy St. Louis and hereby dismisses Mercy St. Louis from Case Nos. 17-1128GC and 17-1130GC.

#### B. Jurisdictional Determination for Remaining Participants

With the exception of the group issues and providers discussed above in Subsection A, the Board has determined that the remaining participants’ appeals involved with the instant EJR Request are governed by CMS Ruling CMS-1727-R. In addition, the

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<sup>38</sup> The Board notes that there are multiple dates on the Model Form E for Mercy St. Louis (*e.g.*, July 16, 2018 and July 18, 2019) and that these dates are later than the July 14, 2018 date that the Provider Representative is alleging on the Schedule of Providers as “the date the Model Form E was sent to the Board.”

remaining participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal<sup>39</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 underlying remaining participants.

*Board's Analysis Regarding the Appealed Issue*

The appeals in these EJR requests involve the 2011 through 2014 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>40</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>41</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) Mercy Hospital Springfield (Provider No. 26-0065, FYE 6/30/2011) is not currently part of Case No. 14-4170GC and, as such, cannot be considered in the Board's determination on this EJR request as it relates to Case No. 14-4170GC.
- 2) It does not have jurisdiction over Mercy Washington in Case No. 14-4170GC and, thus, it dismisses Mercy Washington from Case No. 14-4170GC and from this EJR Determination as it relates to Case No. 14-4170GC;
- 3) It does not have jurisdiction over Mercy Medical Center and Mercy Hospital Lebanon in Case Nos. 15-0385GC and 15-0386GC and, thus, it dismisses these two Providers from Case Nos. 15-0385GC and 15-0386GC and from this EJR Determination as it relates to Case Nos. 15-0385GC and 15-0386GC;

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<sup>39</sup> See 42 C.F.R. § 405.1837.

<sup>40</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>41</sup> See 42 U.S.C. § 1395oo(f)(1).

- 4) It does not have jurisdiction over Mercy St. Louis in Case Nos. 17-1128GC and 17-1130GC and, thus, it dismisses Mercy St. Louis from Case Nos. 17-1128GC and 17-1130GC and from this EJR Determination as it relates to Case Nos. 17-1128GC and 17-1130GC;
- 5) 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;
- 6) 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;
- 7) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 8) 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.  
Gregory H. Ziegler, CPA, CPC-A  
Robert A. Evarts, Esq.  
Susan A. Turner, Esq.

**For the Board:**

5/9/2019

**X** Clayton J. Nix

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Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators





### **Electronic Delivery**

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

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

14-0062GC QRS Asante 2007 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP  
14-0071GC QRS Asante 2007 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Grp  
14-3065GC QRS Asante 2008 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Grp  
14-3066GC QRS Asante 2008 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP  
14-3076GC QRS Asante 2009 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Grp  
14-3077GC QRS Asante 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’ April 26, 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

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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

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*

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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 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. 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.

### **Providers' EJR Request**

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 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 request for Case Nos. 14-3066GC and 14-3077GC *improperly* include Asante Rogue Regional Medical Center (Provider No. 38-0018, FYE 9/30/2008 & 9/30/2009) (“Asante Rogue”) that the Board previously has issued determinations, both dated August 8, 2014, denying jurisdiction over Asante Rogue *and* denying its requests to transfer to Case No. 14-3066GC and 14-3077GC. Accordingly, notwithstanding the Provider Representative’s *improper attempt* to include Asante Rogue on the Schedule of Providers, Asante Rogue is *not currently* part of Case No. 14-3066GC or Case No. 14-3077GC and, as such, cannot be considered in this EJR request as it relates to Case Nos. 14-3066GC and 14-3077GC. 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.

The Board does note that Asante Rogue Regional Medical Center for FYE 9/30/2008 and 9/30/2009 does have proper appeals of the Part C *Medicare* fraction in Case Nos. 14-3065GC and 14-3076GC.

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

Jurisdiction for the 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 2007 through 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 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.

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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.

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 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 2007 through 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) Asante Rogue Regional Medical Center (Provider No. 38-0018, FYE 9/30/2008 & 9/30/2009) ("Asante Rogue") is not currently part of Case No. 14-3066GC or Case No. 14-3077GC and, as such, cannot be considered in this EJR request as it relates to Case Nos. 14-3066GC and 14-3077GC.
- 2) It has jurisdiction over the matter for the subject years and that the current participants in Case Nos. 14-0062GC, 14-0071GC, 14-3065GC, 14-3066GC, 14-3076GC, and 14-3077GC are entitled to a hearing before the Board;

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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).



- 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 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 request for EJR for the issue and the subject years for the current participants in Case Nos. 14-0062GC, 14-0071GC, 14-3065GC, 14-3066GC, 14-3076GC, and 14-3077GC. 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.  
Gregory H. Ziegler, CPA, CPC-A  
Robert A. Evarts, Esq.  
Susan A. Turner, Esq.

**For the Board:**

5/9/2019

**X** Clayton J. Nix

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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

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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***

14-2490GC QRS Scottsdale HC 2008 Medicaid Fraction Medicare Managed Care Part C Days Grp  
14-2491GC QRS Scottsdale HC 2008 SSI Fraction Medicare Managed Care Part C Days Group  
14-2498GC QRS Scottsdale HC 2007 DSH SSI Fraction Medicare Managed Care Part C Days Grp  
14-2500GC QRS Scottsdale HC 2007 DSH Medicaid Fraction Medicare Managed Care Part C Days  
15-3431GC QRS Scottsdale HC 2010 Medicaid Fraction Medicare Managed Care Part C Days Grp  
15-3433GC QRS Scottsdale HC 2010 SSI Fraction Medicare Managed Care Part C Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ April 17, 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>

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

<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 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:

<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>

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

<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).

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.

### **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 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 2010.

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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.”).

<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.

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 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>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.



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 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 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>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.

<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).

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.

Gregory H. Ziegler, CPA, CPC-A

Robert A. Everts, Esq.

Susan A. Turner, Esq.

FOR THE BOARD:

5/9/2019

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)  
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  
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Arcadia, CA 91006

**RE: *EJR Determination***

14-4355GC QRS Scottsdale HC 2011 SSI Fraction Medicare Managed Care Part C Days  
14-4356GC QRS Scottsdale HC 2011 Medicaid Fraction Medicare Managed Care Part C Days  
15-2398GC QRS Scottsdale HC 2012 DSH SSI Fraction Medicare Managed Care Part C Days  
15-2399GC QRS Scottsdale HC 2012 DSH Medicaid Fraction Medicare Mngd Care Part C  
17-0012GC QRS Honor Health 2013 SSI Fraction Medicare Managed Care Part C Days Group  
17-0013GC QRS Honor Health 2013 Medicaid Fraction Medicare Managed Care Part C Days

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 17, 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>

<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>

<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 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> 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 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 2011-2013.

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>

<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.



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.

*A. Jurisdictional Determination in Case Nos. 15-2398GC and 15-2399GC for # 4 Scottsdale Healthcare Thompson aka Honor Health Scottsdale Thompson (Provider No. 05-0123)*

In Case Nos. 15-2398GC and 15-2399GC, Participant #4 Scottsdale Healthcare Thompson (“*Scottsdale Thompson*”) joined as a participant based two different appeals: (1) based on an appeal pursuant to 42 C.F.R. § 405.1835(a)(3)(ii) (2013) for the failure of the Medicare Administrative Contractor (MAC) to issue a Notice of Program Reimbursement (NPR) within 12 months of the receipt of the provider’s cost report; and (2) based on an appeal of the original NPR determination pursuant to § 405.1835(a)(1) (2013).<sup>35</sup> The individual appeal based on the nonissuance of the NPR was assigned Case No. 14-4077. However, Scottsdale Thompson did *not* appeal the Part C Days issue in Case No. 14-4077 from which it transferred to Case Nos. 15-2398GC and 15-2399GC. Rather, the sole issue appealed in Case No. 14-4077 was the outlier issue. The regulation, 42 C.F.R. § 405.1835(b)(2) (2012) requires that, for each specific item at issue, the provider must explain why it is dissatisfied with the MAC determination. Since Scottsdale Thompson did not comply with the regulatory requirements and properly appeal the Part C Days issue in Case No. 14-4077, the Board lacks jurisdiction over the

<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. § 405.1835(a)(3)(ii) (2012).

Part C Days issue purportedly transferred from Case No. 14-4077 to Case Nos. 15-2398GC and 15-2399GC. Accordingly, the Board dismisses from Case Nos. 15-2398GC and 15-2399GC Scottsdale Thompson's appeals from the nonissuance of an NPR under § 405.1835(a)(3)(ii) (2013) that were purportedly transferred from Case No. 14-4077 and, since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board hereby denies Scottsdale Thompson's request for EJR as it relates to 15-2398GC and 15-2399GC but only in connection with Scottsdale Thompson's appeals from the nonissuance of an NPR under § 405.1835(a)(3)(ii) (2013) that were purportedly transferred from Case No. 14-4077.<sup>36</sup> Notwithstanding, as discussed above, the Board notes that Scottsdale Thompson appealed the Part C days issue from the issuance of the original NPR and that issue still remains in Case Nos. 15-2398GC and 15-2399GC for Scottsdale Thompson based on the original NPR appeal.

*B. Jurisdiction and EJR over the Remaining Appeals*

The Board has determined that the remaining participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<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 participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2011-2013 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>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.

<sup>36</sup> See 42 C.F.R. § 405.1842(a).

<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).

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 remaining 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.  
Gregory H. Ziegler, CPA, CPC-A  
Robert A. Evarts, Esq.  
Susan A. Turner, Esq.

For the Board:

5/9/2019

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)  
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**

Isaac Blumberg  
Blumberg Ribner, Inc.  
315 South Beverly Dr, Ste 505  
Beverly Hills, CA 90212-1925

**RE: *EJR Determination***

Touro Infirmary, Provider No. 19-0046  
FYE 12/31/2010  
Case No. 15-2265

Dear Mr. Ribner:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's April 15, 2019 request for expedited judicial review ("EJR") (received April 16, 2019) for the appeal referenced above.<sup>1</sup> The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this case 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>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>

<sup>1</sup> Three other Board Appeals were also included in this request for EJR. The Board is concurrently issuing its decision related to 13-0391, 13-1355 and 13-2062 under separate cover.

<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.*

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 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>

<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).

<sup>12</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>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 care coverage under Medicare Part C were no longer entitled to have payment made for their

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

<sup>14</sup> 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, 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>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:

... *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>

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

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

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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 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 EJIR**

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>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).

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

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

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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 participant in this individual appeal has filed an EJR request involving fiscal year 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>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

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

<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).

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 participant 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 \$10,000, as required for an individual appeal.<sup>36</sup> The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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

The appeal in this EJR request involves the 2010 cost 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 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

<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. § 405.1835(a)(2).

<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).

above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.<sup>39</sup>

Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject year and that the participant in this individual appeal is entitled to a hearing before the Board;
- 2) Based upon the participant's assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(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 Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since other issues remain pending in this case, the appeal will remain open.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

5/9/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

cc: Byron Lamprecht, WPS  
Wilson Leong, FSS

<sup>39</sup> On April 16, 2019, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina I*. 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**

Mr. Robert Roth  
Hooper, Lundy & Bookman P.C.  
401 9<sup>th</sup> Street, NW, Suite 550  
Washington D.C. 20004

**RE: *EJR Determination***

Johnston Health Services Corp, Provider No. 34-0090  
FYE 6/30/2013  
Case No. 18-1099

Dear Mr. Roth:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's April 19, 2019 request for expedited judicial review ("EJR") for the appeal referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this case is:

Whether the Hospital's DSH payment for FY 2013 was understated because it was 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>

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

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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.*

<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:

... 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:

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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 participant in this individual appeal has filed an EJR request involving a September 30, 2013 FYE. 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

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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.).

<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.

The Board has determined that the participant 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 \$10,000, as required for an individual appeal.<sup>35</sup> The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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

The appeal in this EJR request involves a September 30, 2013 cost 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 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

<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. § 405.1835(a)(2).

<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).

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 participant in this individual appeal is entitled to a hearing before the Board;
- 2) Based upon the participant's assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(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 Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since other issues remain pending in these cases, the appeals will remain open.

Board Members Participating:

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

For the Board:

5/10/2019

X Clayton J. Nix

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

cc: Laurie Polson, Palmetto GBA c/o NGS, Inc. (J-M)  
Wilson Leong, FSS



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Mail**

Stephanie Webster, Esq.  
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**RE: Expedited Judicial Review Determination**

14-0674GC Rochester General Health System 2009 SSI Medicare Advantage CIRP Group  
15-0396GC Rochester Regional Health System 2010 SSI Medicare Advantage CIRP Group  
15-0767GC Rochester Regional Health System 2011 SSI Medicare Advantage Group  
15-2565GC Rochester Regional Health System 2012 SSI Fraction Medicare Advantage Days  
15-2566GC Rochester Regional Health System 2012 Medicaid Fraction Medicare Advantage

Dear Mr. Keough:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 19, 2019 request for expedited judicial review ("EJR") (received April 22, 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:

Whether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI<sup>1</sup> fraction and excluded from the Medicaid fraction numerator or vice-versa.<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>

<sup>1</sup> "SSI" is the acronym for "Supplemental Security Income."

<sup>2</sup> Providers' EJR Request at 4.

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

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

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*

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<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>

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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.

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

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

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:

... *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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<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.

*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 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

<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.



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 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 FFY 2005 IPPS Final Rule, 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>30</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>31</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 this case, 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 I*, 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.

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

<sup>30</sup> 69 Fed. Reg. at 49,099.

<sup>31</sup> *Allina* at 1109.

### Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2009-2012.

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>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* at 1258-59.

<sup>34</sup> 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

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

<sup>36</sup> *Banner* 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 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 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 2009-2012 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>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 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>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).

- 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 the 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:

5/14/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Pam VanArsdale, NGS (J-K) (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 Mail**

Isaac Blumberg  
Blumberg Ribner, Inc.  
315 South Beverly Drive  
Suite 505  
Beverly Hills, CA 90212-1925

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

19-1805GC ETRHS 2008-2009 Medicare HMO Part C Days-Medicare Fraction Group  
19-1806GC ETRHS 2008-2009 Medicare HMO Part C Days-Medicaid Fraction Group  
19-1777GC ETRHS 2010 Medicare HMO Part C Days-Medicare Fraction Group  
19-1778GC ETRHS 2010 Medicare HMO Part C Days-Medicaid Fraction Group  
19-1779GC ETRHS 2011 Medicare HMO Part C Days-Medicare Fraction Group  
19-1780GC ETRHS 2011 Medicare HMO Part C Days-Medicaid Fraction Group  
19-1781GC ETRHS 2012-2013 Medicare HMO Part C Days-Medicare Fraction Group  
19-1783GC ETRHS 2012-2013 Medicare HMO Part C Days-Medicaid Fraction Group

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' April 25, 2019 request for expedited judicial review (EJR) (received April 25, 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>

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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 . . . .  
(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>

<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> 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. (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

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<sup>10</sup> 42 C.F.R. § 412.106(b)(4).

<sup>11</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>12</sup>

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

<sup>12</sup> 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).

<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).



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 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>

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<sup>17</sup> 69 Fed. Reg. at 49,099.

<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 §

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. 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 regulation 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.

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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>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 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.

### Jurisdictional Determination

The participants in this EJR request have filed an appeals involving fiscal years 2008-2013.

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 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.

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<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.).

<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.

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 jurisdiction over 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>32</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 EJR requests involve the 2008-2013 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>33</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>34</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

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<sup>32</sup> See 42 C.F.R. § 405.1837.

<sup>33</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>34</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' 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 Board hereby closes these 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:

5/15/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Justin Lattimore, Novitas Solutions (Electronic Mail w/ Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)

**Electronic Mail**

Christopher Keough, Esq.  
Akin Gump Straus Hauer & Feld LLP  
2001 K Street, NW  
Washington, DC 20026

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

15-2251GC Tenet FY 2013 DSH-SSI Fraction Medicare Advantage Days Group

Dear Mr. Keough:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 17, 2019 request for expedited judicial review ("EJR") (received April 18, 2019) for the appeal referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this appeal is:

Whether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI<sup>1</sup> fraction and excluded from the Medicaid fraction numerator or vice-versa.<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

<sup>1</sup> "SSI" is the acronym for "Supplemental Security Income."

<sup>2</sup> Providers' EJR Request at 4.

<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).

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 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>

<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)(l).

<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).

<sup>12</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>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 care coverage under Medicare Part C were no longer entitled to have payment made for their

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

<sup>14</sup> 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, 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



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:

*... 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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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.

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 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 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 FFY 2005 IPPS Final Rule, 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>30</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>31</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 this case, 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 I*, 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 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-

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<sup>30</sup> 69 Fed. Reg. at 49,099.

<sup>31</sup> *Allina I* at 1109.

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. 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>37</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>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* at 1258-59.

<sup>34</sup> 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

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

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

<sup>37</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

*A. Denial of Jurisdiction Over Appeal of a Revised NPR*

#13 Los Alamitos Medical Center (Provider No. 05-0551) appealed a revised NPR for the fiscal year ending May 31, 2013 (“FYE 2013”) that did not adjust the Part C issue as required for Board jurisdiction. The May 12, 2017 Notice of Reopening stated that one of the purposes of the reopening was “[t]o update the SSI percentage and DSH payment percentage per the Provider’s request to recalculate the SSI percentage using their cost report Fiscal Year.”

The regulation, 42 C.F.R. § 412.106(b)(3), permits a provider to request to have its data reported on its cost reporting period instead of the Federal fiscal year. To do so, “[i]t must furnish to CMS, through its Intermediary, a written request including the hospital’s name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital’s official Medicare Part A/SSI percentage for that period.”

Los Alamitos Medical Center requested that its SSI percentage be recalculated from the federal fiscal year to their cost reporting year. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used. The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider’s cost reporting period instead of the September 30 FFY.

The regulation, 42 C.F.R. § 405.1889 (2013), states that:

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

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Since the revised NPR for #13 Los Alamitos Medical Center did not adjust the Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that it lacks jurisdiction

over the revised NPR and hereby dismisses the appeal of the revised NPRs for the Provider. Because jurisdiction over a provider is a requisite to granting a request for EJR, the Board hereby denies the Providers' request for EJR as it relates to the revised NPR for FYE 2013 from Case No. 15-2251GC.<sup>38</sup> The Provider's original NPR appeal for FYE 2013 will remain pending in the case.

*B. Jurisdiction and EJR for the Remaining Providers*

The Board has determined that the remaining participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. The appeals of remaining revised NPRs have adjustments to Part C days, as required. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>39</sup> The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction over the above-captioned appeal 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 appeal in this EJR request involves the cost reporting period 2013. Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the 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>40</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>41</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 remaining participants in this group appeal are entitled to a hearing before the Board;

<sup>38</sup> See 42 C.F.R. § 405.1842(a).

<sup>39</sup> See 42 C.F.R. § 405.1837.

<sup>40</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>41</sup> See 42 U.S.C. § 1395oo(f)(1).

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


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

Board Members Participating:

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

FOR THE BOARD:

5/15/2019

 Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosure: Schedule of Providers

cc: Justin Lattimore, Novitas Solutions (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

Lucile Salter Packard Children's Hospital at Stanford  
Ms. Melanie Davidson  
725 Welch Road  
Palo Alto, CA 94304

Noridian Healthcare Solutions  
Ms. Lorriane Frewert  
Appeals Coordinator, JE Provider Audit  
P.O. Box 6782  
Fargo, ND 58108-6782

**RE: Lucile Salter Packard Children's Hospital at Stanford**

Provider No.: 05-3305  
FYE: 8/31/15  
PRRB Case No.: 19-0941

Dear Ms. Davidson and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in case number 19-0941. The decision of the Board is set forth below.

**Background:**

The Provider was issued a Final Determination of Adjustments to the TEFRA Limit (Exception Request) on June 4, 2018. The Board received the Provider's appeal request in which it is "requesting the Board to order the Medicare Contractor to issue an adjustment for the addition . . . of services" on December 10, 2018, which is 189 days after the date of the final determination.<sup>1</sup>

**Board Decision:**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is \$10,000 or more (or \$50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. In accordance with 42 C.F.R. § 405.1801(a) and PRRB Rule 4.5, the date of filing is the date stamped "received" by the Board on documents submitted by regular mail, hand delivery, or couriers not recognized as a national next-day courier.

Under these provisions, the Provider has 180 days from its receipt of the final determination (with a five-day presumption for mailing) to file its appeal request with the Board. The final determination was dated June 4, 2018 and it is presumed that the Provider received it 5 days later, on June 9, 2018. The Provider had 180 days from June 9, 2018 to file its appeal, which means the Provider's appeal request was due to

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<sup>1</sup> See Provider's Individual Appeal Request, December 10, 2018.



the Board by December 6, 2018. The Board received the Provider's appeal via FedEx on December 10, 2018, which is 189 days after the date of the final determination and therefore untimely filed.

**Conclusion:**

The Board finds that it does not have jurisdiction over the Individual Appeal for fiscal year end ("FYE") August 31, 2015 as it was not timely filed pursuant to 42 C.F.R. § 405.1835(a)(3) and dismisses case number 19-0941.

A 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.

5/16/2019

**X** Charlotte F. Benson

Charlotte F. Benson, CPA  
Board Member  
Signed by: PIV

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board  
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**Electronic Mail**

Robert L. Roth, Esq.  
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401 9th Street, NW  
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Washington, D.C. 20004

**RE: *Expedited Judicial Review Determination***  
17-2136GC UNC 2013 DSH Part C Days Medicaid and Medicare/SSI Fractions Group

Dear Mr. Roth:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 23, 2019 request for expedited judicial review ("EJR"), for the above-referenced appeal. The Board's determination is set forth below.

**Issue in Dispute**

The issue in this appeal is:

Whether the Hospitals' FY 2008 Medicare DSH [*i.e.* disproportionate share hospital] payments were understated because (a) the numerator of the Medicaid fraction improperly excluded inpatient hospital days attributable to dually-eligible Medicare Part C plan enrollee patients and (b) the Medicare/SSI fraction 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>

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 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).

<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 . . . . (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 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.

<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).

<sup>10</sup> 42 C.F.R. § 412.106(b)(4).

§ 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>

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

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<sup>11</sup> of Health and Human Services.

<sup>12</sup> 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).

<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).

*... 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 IPSS 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 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 IPSS 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 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>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 IPSS final rule published on August 15, 2010,

<sup>16</sup> 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

<sup>17</sup> 69 Fed. Reg. at 49,099.

<sup>18</sup> *Id.*

<sup>19</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>20</sup> 72 Fed. Reg. at 47411.

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. 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 are challenging the inclusion of Part C days in the Medicare/SSI fraction and the exclusion of dually-eligible Medicare Part C days from the numerator of the Medicaid fraction, used to calculate their DSH payments based on the Secretary’s invalid rulemaking in the FFY 2005 IPPS Final Rule (which the Secretary improperly sought to impose without notice and comment in the rulemaking in the FFY 2008 IPPS Final Rule codifying the Part C days policy at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B)). The Providers note that although the Board has jurisdiction over the DSH Medicare Part C Days Medicaid and Medicare/SSI fractions issue, they believe that the Board lacks the authority to make any changes to CMS policy. They believe that EJR is appropriate where there is a challenge over the substantive and procedural validity of the rule requiring the inclusion of Part C days in the Medicare/SSI fraction.

### **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

<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 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.

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 appeals involving fiscal year 2013.

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 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.

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<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.).

<sup>28</sup> 108 S. Ct. 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> *Id.* at 142.

The Board has determined that participants involved with the instant EJR requests of Medicare Part C days issue are governed by CMS Ruling-1727-R, consequently, the Board has jurisdiction over the appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal<sup>32</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 this EJR request involve the 2013 cost 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 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>33</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>34</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 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>32</sup> See 42 C.F.R. § 405.1837.

<sup>33</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>34</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 there are no other issues under dispute in this case, the case is 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:

5/16/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedule of Providers

cc: Laurie Polson, Palmetto(Electronic Mail w/ Schedule of Providers)  
Wilson Leong, Esq., Federal Specialized Services (Electronic Mail w/Schedule 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**

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**RE: EJR Determination**

13-1842GC ProMedica 2008 SSI Ratio Medicare Advantage Days CIRP Group  
15-1104GC Advocate Health 2010 DSH Medicare/Medicaid Fraction Part C Days CIRP Group  
15-3081GC MediSys Health Network 2012 DSH Medicare/Medicaid Part C Days CIRP  
15-3452GC Community Healthcare System 2013 DSH Part C Days CIRP Group  
16-1136GC Hall Render Northshore Univ. 2011 DSH Medicare/Medicaid Fraction Part C Days CIRP  
16-1188GC MediSys Health Network 2013 DSH Part C Days CIRP Group  
16-1337GC Genesis Health System 2009 DSH Part C Days CIRP Group  
16-1885GC Advocate Health 2011 DSH Medicare/Medicaid Fraction Part C Days CIRP Group  
16-2023GC Advocate 2009 Medicare/Medicaid Part C Days CIRP

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 26, 2019 request for expedited judicial review ("EJR") (received April 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:

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

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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).

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 not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days*

<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.

*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. 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

<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).

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 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 that comprise the group appeals within this EJR request have filed appeals involving fiscal years 200 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>30</sup> In that case, the Supreme Court concluded that a cost

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

<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

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.

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. 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 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.

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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. § 405.1837.



### Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2008 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>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.<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 remaining participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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

<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> On April 29, 2019, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in two 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 federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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:

5/16/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Bryon Lamprecht, WPS (J-8)  
Judith Cummings, CGS (J-15)  
Danene Hartley, National Government Services (J-6)  
Pam VanArsdale, National Government Services (J-K)  
Wilson Leong, FSS



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

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

**RE: *EJR Determination***

15-0567GC QRS BJC 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP  
15-0568GC QRS BJC 2010 DSH SSI Fraction Medicare Managed Care Days CIRP  
15-2590GC QRS BJC 2012 DSH SSI Fraction Medicare Managed Care Days CIRP  
15-2640GC QRS BJC 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP  
17-0837GC QRS BJC 2013 DSH SSI Fraction Medicare Managed Care Days CIRP  
17-0838GC QRS BJC 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 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>

**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 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

<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).

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 IIMO. 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 *not adopting as final our proposal*

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<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.

*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. More recently, in *Allina Health Services v. Price* (“*Allina IP*”),<sup>26</sup> the D.C. Circuit confirmed that

<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).

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 2010, 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*

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

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

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



*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.

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 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

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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. § 405.1837.

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 2010, 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.<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 IPPS final rule are valid.

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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).

<sup>38</sup> On May 2, 2019, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in each of the 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 federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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

FOR THE BOARD:

5/16/2019

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)



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Washington, DC 20026

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

14-4231GC Tenet FY 2012 SSI Fraction Medicare Advantage Days Group

Dear Mr. Keough:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 17, 2019 request for expedited judicial review ("EJR") (received April 18, 2019) for the appeal referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this appeal is:

Whether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI<sup>1</sup> fraction and excluded from the Medicaid fraction numerator or vice-versa.<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

<sup>1</sup> "SSI" is the acronym for "Supplemental Security Income."

<sup>2</sup> Providers' EJR Request at 4.

<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).

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 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>

<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).

<sup>12</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>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 DSII 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

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

<sup>14</sup> 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, 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>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:

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

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

<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.

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 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 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 FFY 2005 IPPS Final Rule, 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>30</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>31</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 this case, 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 I*, 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.

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<sup>30</sup> 69 Fed. Reg. at 49,099.

<sup>31</sup> *Allina I* at 1109.

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. 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

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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. 30,190, 30,240 (May 23, 2008).

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

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

contractor specifically revised within the revised NPR.<sup>37</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

*A. Jurisdiction over Certain Appeals of Revised Notices of Program Reimbursement (NPRs)*

*1. Revised NPRs for SSI Realignment*

The Providers below appealed revised NPRs that implement a realigned SSI percentage (to the Providers cost reporting year end), but not specifically adjust the Part C days issued under appeal as required by 42 C.F.R. § 405.1889 for Board jurisdiction:

- #42 Sinai Grace Hospital (Provider No. 23-0024),
- #44 Harper Hutzler Hospital (Provider No. 23-0104),
- #64 Valley Baptist Medical Center (Provider No. 45-0028), and
- #75 Cypress Fairbanks Medical Center (Provider No. 45-0716).

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

The Providers requested that their SSI percentages be recalculated from the federal fiscal year to their cost reporting year. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used. The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the federal fiscal year which ends September 30th.

*2. Revised NPR That Adjusted Medicaid Eligible Days*

The following Provider appealed a revised NPR that increased the number of days in the DSH calculation, but did not document that the specific category of Part C days under appeal were adjusted on the revised NPR as required by 42 C.F.R. § 405.1889 for Board jurisdiction over a the Part C Days issue:

- #72 Sierra Medical Center (Provider No. 45-0668).

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<sup>37</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

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

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

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

3. *Jurisdictional Determination Over Revised NPR Appeals*

Based on the above, the Board concludes that it lacks jurisdiction over the following providers as it relates to the appeal of their revised NPR because the revised NPRs at issue did not adjust the Part C days issue as required by 42 C.F.R. § 405.1889:

#42 Sinai Grace Hospital,  
#44 Harper Hutzell Hospital,  
#64 Valley Baptist Medical Center,  
#72 Sierra Medical Center, and  
#75 Cypress Fairbanks Medical Center.

Accordingly, the Board hereby dismisses the appeals of the revised NPRs for these providers from Case No. 14-4231GC. Since jurisdiction over a provider is a prerequisite to granting a request for EJR, the Board hereby denies these providers' request for EJR as it relates to their revised NPR appeals in Case No. 14-4231GC.<sup>38</sup> Notwithstanding, each of these five providers appealed their *original* NPR and their *original* NPR appeals will remain pending in the case.

B. *Jurisdiction Over Certain Hearing Requests That Were Not Timely Filed*

Providers # 6 Doctors Hospital of Manteca (Provider No. 05-0118) and # 47 Huron Valley-Sinai Hospital (Huron Valley) (Provider No. 28-0227) did not file their

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<sup>38</sup> See 42 C.F.R. § 405.1842(a).

respective appeals within 185 days of the issuance of their NPRs as required. Doctors Hospital of Manteca's NPR was issued on February 24, 2015, and its appeal was received on September 4, 2015,<sup>39</sup> 193 days after the issuance of the final determination. Huron Valley's NPR was issued February 26, 2015, and its appeal was received on September 4, 2015,<sup>40</sup> 191 days after the issuance of the NPR.

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, among other things, it is dissatisfied with the final determination of the intermediary and 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.<sup>41</sup> In this case, the hearing requests were received more than 185 days after the presumed date of receipt of the NPRs.<sup>42</sup> Consequently, # 6 Doctors Hospital of Manteca's and #47 Huron Valley's appeals were not timely filed and the Board hereby dismisses the Providers from the case. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Providers' request for EJR is hereby denied.

*C. Non-issuance of an NPR*

Pursuant to 42 C.F.R. § 405.1835(c) a provider has the right to a hearing where:

(1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.

(2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the

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<sup>39</sup> The Schedule of Providers indicated that the hearing request for Manteca was received on August 28, 2015; however, the Board's dated stamp on the hearing request in the jurisdictional documents indicates that the Board received the hearing request on September 4, 2015.

<sup>40</sup> The Schedule of Providers indicated that the hearing request for Huron Valley was received on August 28, 2015, however, the Board's date stamp on the hearing request in the jurisdictional documents indicates that the Board received the hearing request on September 4, 2015.

<sup>41</sup> 42 C.F.R. § 405.1801(a)(1)(iii).

<sup>42</sup> See 42 C.F.R. § 405.1835(a)(3)(i).

expiration of the 12 month period for issuance of the final contractor determination . . .

In conjunction with the promulgation of these regulations, the Board issued the following instructions<sup>43</sup> for appeals filed from the non-issuance of NPRs, requiring the following information be submitted with hearing requests:

7.4 – Failure to Timely Issue Final Determination If your appeal is based on the failure of the Intermediary to timely issue a final determination, provide a copy of:

- 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 [Medicare Administrative Contractor (MAC)] letter/e-mail acknowledging receipt of the as-filed and any amended cost reports,
- evidence of the [MAC's] acceptance or rejection of the as-filed and any amended cost reports . . .<sup>44</sup>

Rule 21.A. requires the same documentation be placed under Tab A of the jurisdictional documents that accompanies the Schedule of Providers.

In this case, Providers #5 Paradise Valley Hospital (Provider No. 03-0083), #35 MacNeal Memorial Hospital (Provider No. 14-0054) and # 46 Huron Valley-Sinai Hospital (Provider No. 23-0277) state on the Schedule of Providers that their appeals were filed 181 days, 181 days, and 184 days after the alleged receipt of the cost report. However, the Board cannot verify this assertion because the Providers did not file evidence of receipt of the cost report as required by the Board's Rules and because nor did the Providers submit any of the other information required in the Board's rules when filing an appeal of the non-issuance of an NPR. Moreover, the appeals were not timely filed by the Group Representative own admission. Therefore, the Board concludes that it lacks jurisdiction over the Providers and hereby dismisses #5 Paradise Valley Hospital, #35 MacNeal Memorial Hospital, and # 46 Huron Valley-Sinai Hospital from this case. Since jurisdiction over a provider is a prerequisite to granting a request for EJR, the Board denies #5 Paradise Valley Hospital, #35 MacNeal Memorial, and #46 Huron Valley-Sinai Hospital requests for EJR. Notwithstanding, MacNeal Memorial Hospital

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<sup>43</sup> The Board's Rules can be found on the internet at [https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRules\\_03\\_01\\_2013.pdf](https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRules_03_01_2013.pdf).

<sup>44</sup> PRRB Board Rules effective March 1, 2013.

appealed its *original* NPR and, as such, its *original* NPR appeals will remain pending in this case.

*D. Jurisdiction and EJRs for the Remaining Providers*

The Board has determined that the remaining participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. The remaining appeals of revised NPRs have adjustments to Part C days, as required. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>45</sup> The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction over the above-captioned appeal 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 appeal in this EJR request involves the cost reporting period 2012, thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. 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). *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). 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. *See* 42 U.S.C. § 1395oo(f)(1). 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 remaining 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>45</sup> *See* 42 C.F.R. § 405.1837.

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

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

Board Members Participating:

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

FOR THE BOARD:

5/17/2019

**X** Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Justin Lattimore, Novitas Solutions (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  
Quality Reimbursement Services  
150 N. Santa Anita Ave., Ste 570A  
Arcadia, CA 91006

**RE: *EJR Determination***

QRS Providence 2011 DSH Medicaid Fraction /Medicare Mngd Care Part C Days CIRP Grp  
Case No. 15-0434GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 1, 2019 request for expedited judicial review ("EJR") for the appeal referenced above.<sup>1</sup> The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this appeal 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>

**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>

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<sup>1</sup> This EJR request also included case number 13-3954GC. A decision in that case will be sent under separate cover.

<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.*

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>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>

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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.

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

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

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:

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

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<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.

*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 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

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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).

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 year 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*

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

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

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

*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 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

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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. § 405.1837.

above-captioned appeal and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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

The appeals in this EJR request involves the 2011 cost 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 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 year. The Providers

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<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).



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

Board Members Participating:

Clayton J. Nix, Esq.

Charlotte F. Benson, CPA

Gregory H. Ziegler, CPA, CPC-A

Robert A. Everts, Esq.

Susan A. Turner, Esq.

FOR THE BOARD:

5/21/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedule of Providers

cc: John Bloom, Noridian (Electronic Mail w/Schedule of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedule of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board  
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410-786-2671

**Electronic Mail**

Christopher Keough, Esq.  
Akin Gump Straus Hauer & Feld LLP  
2001 K Street, NW  
Washington, DC 20026

**RE: *Expedited Judicial Review Determination***  
14-4229GC Tenet FY 2012 SSI Fraction Medicare Advantage Days Group

Dear Mr. Keough:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 17, 2019 request for expedited judicial review ("EJR") (received April 18, 2019) for the appeal referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this appeal is:

Whether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI<sup>1</sup> fraction and excluded from the Medicaid fraction numerator or vice-versa.<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

<sup>1</sup> "SSI" is the acronym for "Supplemental Security Income."

<sup>2</sup> Providers' EJR Request at 4.

<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).

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 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>

<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)(l).

<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).

<sup>12</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>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 care coverage under Medicare Part C were no longer entitled to have payment made for their

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

<sup>14</sup> 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, codified as 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rul.- 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>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:

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

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

<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.

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 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.

<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 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>30</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>31</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 this case, 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 I*, 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.

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<sup>30</sup> 69 Fed. Reg. at 49,099.

<sup>31</sup> *Allina* at 1109.

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*.<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. 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

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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* at 1258-59.

<sup>34</sup> 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

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

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



contractor specifically revised within the revised NPR.<sup>37</sup> The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

*A. Appeals of Revised Notices of Program Reimbursement (NPRs) with Original NPR Appeals*

*1. Revised NPRs with SSI Realignment*

The Providers below appealed revised NPRs that implement a realigned SSI percentage (to the Providers cost reporting year end), but do not specifically adjust the Part C days issued under appeal as required by 42 C.F.R. § 405.1889 for Board jurisdiction:

- # 5 Abrazo Central Commons (Provider No. 03-0030),
- #45 Sinai Grace Hospital (Provider No. 23-0024),
- #47 Harper Hutzell Hospital (Provider No. 23-0104), and
- #78 Cypress Fairbanks Medical Center (Provider No. 45-0716).

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

The Providers requested that their SSI percentages be recalculated from the federal fiscal year to their cost reporting year. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used. The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the federal fiscal year which ends September 30th.

*2. Revised NPRs that Adjusted Medicaid Eligible Days*

Each of the following Providers appealed a revised NPR that generally adjusted DSH eligible days but did not document that the specific category of Part C days under appeal were adjusted on the revised NPR as required by 42 C.F.R. § 405.1889 for Board jurisdiction over a the Part C Days issue:

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<sup>37</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

#67 Valley Baptist Medical Center (Provider No. 45 0028),  
#74 Sierra Medical Center (Provider No. 45-0668), and  
#76 Doctors Hospital at White Rock (Provider No. 45-0678).

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

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

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

### 3. *Jurisdictional Determination over Revised NPR Appeals*

Based on the above, the Board concludes that it lacks jurisdiction over the following providers at it relates to the appeal of their revised NPR because the revised NPRs at issue did not adjust the Part C days issue as required by 42 C.F.R. § 405.1889:

#5 Abrazo Central Commons,  
#45 Sinai Grace Hospital,  
#47 Harper Hutzell Hospital,  
#78 Cypress Fairbanks Medical Center,  
#67 Valley Baptist Medical Center,  
#74 Sierra Medical Center, and  
#76 Doctors Hospital at White Rock.

Accordingly, the Board hereby dismisses the appeals of the revised NPRs for these providers from Case No. 14-4229GC. Since jurisdiction over a provider is a prerequisite to granting a request for EJR, the Board hereby denies these providers' request for EJR based as it relates to their revised NPRs appeals in Case No. 14-4229GC. Notwithstanding, each of these seven providers appealed their *original* NPR and their *original* NPR appeals will remain pending in this case.

*B. Hearing Request that were not Timely Filed*

Providers # 8 Doctors Hospital of Manteca (Provider No. 05-0118) and # 49 Huron Valley-Sinai Hospital ("Huron Valley") (Provider No. 28-0227) did not file their respective appeals within 185 days of the issuance of their NPRs as required. Doctors Hospital of Manteca's NPR was issued on February 24, 2015, and its appeal was received on September 4, 2015,<sup>38</sup> 193 days after the issuance of the final determination. Huron Valley's NPR was issued February 26, 2015, and its appeal was received on September 4, 2015,<sup>39</sup> 191 days after the issuance of the NPR.

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, among other things, it is dissatisfied with the final determination of the intermediary and 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.<sup>40</sup> In this case, the hearing requests were received more than 185 days after the presumed date of receipt of the NPRs.<sup>41</sup> Consequently, # 8 Doctors Hospital of Manteca's and #49 Huron Valley's appeals were not timely filed and the Board hereby dismisses the Providers from the case. Since jurisdiction over an appeal is a prerequisite to granting a request for EJRs, the Providers' request for EJRs is hereby denied.

*C. Non-issuance of an NPR*

Pursuant to 42 C.F.R. § 405.1835(c) a provider has the right to a hearing where:

- (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a

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<sup>38</sup> The Schedule of Providers indicated that the hearing request for Manteca was received on August 28, 2015; however, the Board's dated stamp on the hearing request in the jurisdictional documents indicates that the Board received the hearing request on September 4, 2015.

<sup>39</sup> The Schedule of Providers indicated that the hearing request for Huron Valley was received on August 28, 2015. However, the Provider included in the jurisdictional documents the Board's copy of the hearing request showing the Board's "received" date stamp on that copy confirming that the Board received the hearing request on September 4, 2015. The Board generally considers the Board's "received" date stamp as authoritative.

<sup>40</sup> 42 C.F.R. § 405.1801(a)(1)(iii).

<sup>41</sup> See 42 C.F.R. § 405.1835(a)(3)(i).

preponderance of the evidence that the contractor received the cost report on an earlier date.

(2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination . . .

In conjunction with the promulgation of these regulations, the Board issued the following instructions<sup>42</sup> for appeals filed from the non-issuance of NPRs, requiring the following information be submitted with hearing requests:

7.4 – Failure to Timely Issue Final Determination If your appeal is based on the failure of the Intermediary to timely issue a final determination, provide a copy of:

- 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 [Medicare Administrative Contractor (MAC)] letter/e-mail acknowledging receipt of the as-filed and any amended cost reports,
- evidence of the [MAC's] acceptance or rejection of the as-filed and any amended cost reports . . .<sup>43</sup>

Board Rule 21.A. requires the same documentation be placed under Tab A of the jurisdictional documents that accompanies the Schedule of Providers.

In this case, Providers #7 Paradise Valley Hospital (Provider No. 03-0083), #38 MacNeal Memorial Hospital (Provider No. 14-0054) and # 50 Huron Valley-Sinai Hospital (Provider No. 23-0277) assert on the Schedule of Providers that their appeals were filed 181 days, 181 days, and 184 days after the alleged submission of the cost report. However, the Board could not verify this assertion because the Providers did not file evidence of the Medicare contractor's receipt of the cost report as required by the Board's Rules and because the Providers did not submit any of the other information required in the Board's Rules when filing an appeal of the non-issuance of an NPR. Moreover, the

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<sup>42</sup> The Board's Rules can be found on the internet at [https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRules\\_03\\_01\\_2013.pdf](https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRules_03_01_2013.pdf).

<sup>43</sup> PRRB Board Rules effective March 1, 2013.

appeals were *not* timely filed by the Group Representative own admission since the listed days were in excess of 180 days period allotted for appeal under 42 C.F.R.

§ 4.05.1835(c)(2) as quoted above. Therefore, the Board concludes that it lacks jurisdiction over the Providers and hereby dismisses #7 Paradise Valley Hospital, #38 MacNeal Memorial Hospital and # 50 Huron Valley-Sinai Hospital from this case. Since jurisdiction over a provider is a prerequisite to granting a request for EJR, the Board denies #7 Paradise Valley Hospital, #38 MacNeal Memorial, and #50 Huron Valley-Sinai Hospital requests for EJR. Notwithstanding, MacNeal Memorial Hospital appealed its *original* NPR and, as such, its *original* NPR appeals will remain pending in this case.

*D. Jurisdiction and EJR for the Remaining Providers*

The Board has determined that the *remaining* participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. The remaining appeals of revised NPRs have adjustments to Part C days, as required. In addition, the 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 over the above-captioned appeal 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 appeal in this EJR request involves the cost reporting period 2012. Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the 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, 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.

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<sup>44</sup> See 42 C.F.R. § 405.1837.

<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).

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

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

Board Members Participating:

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

FOR THE BOARD:

5/17/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosure: Schedule of Providers

cc: Justin Lattimore, Novitas Solutions (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 Mail**

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

15-1774GC Tenet FY 2013 Medicaid Fraction Medicare Advantage Days Group

Dear Mr. Keough:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 17, 2019 request for expedited judicial review ("EJR") (received April 18, 2019) for the appeal referenced above. The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this appeal is:

Whether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI<sup>1</sup> fraction and excluded from the Medicaid fraction numerator or vice-versa.<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

<sup>1</sup> "SSI" is the acronym for "Supplemental Security Income."

<sup>2</sup> Providers' EJR Request at 4.

<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).

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 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>

<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).

<sup>12</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>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 care coverage under Medicare Part C were no longer entitled to have payment made for their

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

<sup>14</sup> 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, 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

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:

... 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>

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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.

<sup>21</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>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 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.

<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 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 FFY 2005 IPPS Final Rule, 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>30</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>31</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 this case, 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 I*, 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 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-

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<sup>30</sup> 69 Fed. Reg. at 49,099.

<sup>31</sup> *Allina* at 1109.

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. 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>37</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>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. 30,190, 30,240 (May 23, 2008).

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

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

<sup>37</sup> See 42 C.F.R. § 405.1889(b)(1) (2008).

A. *Jurisdiction over Certain Appeals of a Revised NPR*

#13 Los Alamitos Medical Center (Provider No. 05-0551) and # 27 West Boca Medical Center (Provider No. 10-0268) appealed their revised NPRs that did not adjust the Part C issue as required for Board jurisdiction. Rather, for each provider, it was an appeal of an adjustment implementing the *realigned* SSI ratio.

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

The Los Alamitos Medical Center and West Boca Medical Center requested that their SSI percentages be recalculated from the federal fiscal year to their respective cost reporting years. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used. The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the federal fiscal year which ends September 30th.

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

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

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Since the revised NPRs at issue for #13 Los Alamitos Medical Center and #27 West Boca Medical Center did not adjust the Part C days issue as required by 42 C.F.R.

§ 405.1889, the Board finds that it lacks jurisdiction over the revised NPRs and hereby dismisses the appeal of the revised NPRs for both #13 Los Alamitos Medical Center and #27 West Boca Medical Center. Because jurisdiction over a provider is a requisite to granting a request for EJR, the Board hereby denies the Providers' request for EJR as it relates to the revised NPRs from Case No. 15-1774GC.<sup>38</sup> Notwithstanding, both Provider's original NPR appeals will remain pending in the case.

*B. Jurisdiction and EJR over the Remaining Providers*

The Board has determined that the remaining participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. The appeals of the remaining revised NPRs have adjustments to Part C days, as required. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>39</sup> The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction over the above-captioned appeal 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 appeal in this EJR request involves the cost reporting period 2012. Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the 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>40</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>41</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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<sup>38</sup> See 42 C.F.R. § 405.1842(a).

<sup>39</sup> See 42 C.F.R. § 405.1837.

<sup>40</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>41</sup> See 42 U.S.C. § 1395oo(f)(1).

Board's Decision Regarding the EJ R Request

The Board finds that:

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


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

Board Members Participating:

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

FOR THE BOARD:

5/17/2019

 Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Justin Lattimore, Novitas Solutions (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  
Quality Reimbursement Services  
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Arcadia, CA 91006

**RE: *EJR Determination***

14-4169GC Mercy Health 2011 Medicaid Fraction Part C Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 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 this appeal 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 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>

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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).

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.

### 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

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<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.

(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 year 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-disallowing specific items had to do so by following the procedures for filing a cost report under

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

<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 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. Jurisdiction over Certain Late Appeals

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 amount in controversy is \$50,000 or more in a group appeal and the provider’s request for hearing is received by the Board within 180 days of the date of receipt of the final determination by the provider. The following Providers did not file appeals within 180 days of the receipt of their respective NPRs: #1 Mercy Hospital Independence (Provider No. 17-0010); #3 Mercy Medical Center (Provider No. 04-0010); #11 Mercy Health Center (Provider No. 37-0013) and #12 Mercy Hospital El Reno (Provider No. 37-0011).<sup>35</sup>

The NPRs are presumed to have been received 5 days after the date of issuance by the Medicare Administrative Contractor.<sup>36</sup> In this case, the hearing requests for the above referenced Providers were received (filed) more than 185 days after the presumed date of receipt of the NPRs as required by 42 C.F.R. § 405.1835(a)(3) and, therefore, were not timely filed. Consequently, the Board hereby dismisses #1 Mercy Hospital Independence (Provider No. 17-0010); #3 Mercy Medical Center (Provider No. 04-0010); #11 Mercy Health Center (Provider No. 37-0013) and #12 Mercy Hospital El Reno (Provider No.

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

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

<sup>35</sup> In this case, none of the Providers entered the correct date of the receipt of their respective hearing requests in Column B of the Schedule of Providers. The Board reviewed the overnight carriers’ receipts, and, where there was no overnight carrier’s receipt, the case file for the Board date stamps for receipt and its computerized docketing system to determine the date of receipt (*see* 42 C.F.R. § 405.1801(a)(2)(i)) and then calculated the correct number of days between the issuance of the NPRs and the receipt of the hearing requests. This information is reflected on the Schedule of Providers attached to this decision.

<sup>36</sup> 42 C.F.R. § 405.1801(a)(1)(iii).

37-0011) from the appeal. Because jurisdiction over a provider is a prerequisite to granting EJR, the Providers request for EJR is denied.<sup>37</sup>

*B. Jurisdiction and EJR for the Remaining Providers*

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>38</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 request involves the 2011 cost 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 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 year and that the remaining participants in this group appeal are entitled to a hearing before the Board;

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<sup>37</sup> See 42 C.F.R. § 405.1842(a).

<sup>38</sup> See 42 C.F.R. § 405.1837.

<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 federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.



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

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

Board Members Participating:

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

FOR THE BOARD:

5/17/2019

 Clayton J. Nix

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

Enclosures: Schedule of Providers

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

Quality Reimbursement Services, Inc.  
Mr. James Ravindran  
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Arcadia, CA 91006

WPS Government Health Administrators  
Mr. Byron Lamprecht  
Supervisor – Cost Report Appeals  
2525 N 117<sup>th</sup> Avenue, Suite 200  
Omaha, NE 68164

**RE: Stormont – Vail Regional Health Center**  
Provider No.: 17-0086  
FYE: 09/30/2011  
PRRB Case No.:15-2952

Dear Mr. Ravindran and Mr. Lamprecht,

The Provider Reimbursement Review Board (“Board”) has reviewed the jurisdictional documents in case number 15-2952. The decision of the Board is set forth below.

**Background:**

The Provider is appealing the amount of Medicare Reimbursement as determined by its Medicare Administrative Contractor (“Medicare Contractor”) in an Original Notice of Program Reimbursement (“NPR”) issued on January 9, 2015. The Provider filed a timely appeal from the NPR on February 24, 2016. Nine issues were enumerated in the Model Form A – Individual Appeal Request, Tab 3:

- 1) DSH/SSI (Provider Specific)
- 2) DSH/SSI Percentage
- 3) DSH/SSI/Medicare Managed Care Part C Days
- 4) DSH/SSI Fraction/Dual Eligible Days/Part A Days
- 5) DSH/Medicaid Eligible Days
- 6) DSH/Medicaid Fraction/Medicare Managed Care Part C Days
- 7) DSH/ Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
- 8) DSH/ Medicaid Eligible Labor Room Days
- 9) Nursing Program Adjustments

On February 24, 2016 the Provider requested that issues two, three, four, six and seven be transferred to group appeals.<sup>1</sup> On September 14, 2017 the Provider requested that issue nine be withdrawn.<sup>2</sup> On December 20, 2017 the Provider requested that issue eight be withdrawn.<sup>3</sup> On January 19, 2018 the Provider requested that issue five be withdrawn.<sup>4</sup> Only one issue remains pending: SSI Provider Specific.

The Medicare Contractor raised a jurisdictional challenge dated, September 23, 2015 and the Provider issued a jurisdictional response dated, October 28, 2015.

**Medicare Contractor’s Jurisdictional Challenge:**

The Medicare Contractor contends that the Provider is not challenging a final determination, but would like to change the time period upon which the SSI calculation is based from the federal fiscal year to the Provider’s cost report period. The Medicare Contractor asserts that the issue is “suitable for reopening, but is not an appealable issue.”<sup>5</sup> The Medicare Contractor contends that whether or not to realign a hospital’s SSI percentage is not a decision for the Medicare Contractor, rather the hospital must make a formal request through the Medicare Contractor to CMS to receive a realigned percentage. However, once the hospital “elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.”<sup>6</sup> The Medicare Contractor further contends that since it did not make an actual determination, “the PRRB does not have jurisdiction over the issue . . . the Provider’s right to a hearing derives from an intermediary or CMS determination, which is defined at 42 C.F.R. § 405.1801 (a) is a determination of the amount of total reimbursement due to the Provider . . . following the close of the Provider’s cost reporting period.”<sup>7</sup> The Medicare Contractor notes that the Provider’s fiscal year end is the same as the federal fiscal year end, thus the computation for the would be the same for both.

The Medicare Contractor contends that the DSH/SSI Provider Specific realignment issue is duplicative of the SSI Systemic issue and that the Provider is appealing its SSI percentage as separate issues and that it is duplicative.

**Provider’s Jurisdictional Response:**

In response to the Medicare Contractor’s contention that the DSH/SSI Provider Specific realignment issue is duplicative of the SSI Systemic issue, the Provider cites Rule 8.1 stating in part, “Some issues may have multiple components. To comply with the regularity requirement to specifically identify the items in dispute, each contested components must be appealed as a separate issue and described as narrowly as possible. . . .”<sup>8</sup> The Provider argues that since DSH/SSI Provider Specific issues represent different components of the SSI issue . . . that the Board should find jurisdiction over both issues.”

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<sup>1</sup> See Model Form D – Request to Transfer Issues to Group Appeals: 15-3031G; 15-3032G; 15-3037G; 15-3038G; and 15-3039G.

<sup>2</sup> See Notice of Withdrawal of Issue from Appeal (Sept. 30, 2017).

<sup>3</sup> See Notice of Withdrawal of Issue from Appeal (Dec. 26, 2017).

<sup>4</sup> See Notice of Withdrawal of Issue from Appeal (Jan. 19, 2018).

<sup>5</sup> See Medicare Contractor Jurisdictional Challenge (Sept. 23, 2015).

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

<sup>7</sup> *Id.*

<sup>8</sup> See Provider Jurisdictional Response (Oct. 28, 2015).

The Provider contends that it is not addressing a realignment issue, but addressing “various errors of omission and commission that do not fit in the systemic errors category.”<sup>9</sup> The Provider contends that DSH/SSI is appealable because the Medicare Contractor did adjust the Provider’s SSI percentage and the Provider is dissatisfied. The Provider relies in part on *Northeast Hospital Corporation v. Sebelius* (“*Northwest*”). In *Northwest* the court abandoned the Administrator’s December 1, 208 decision that the SSI ratio cannot be revised based upon uploaded data after it has been calculated by CMS. 657 F. 3d 1 (D.C. Cir. 2011). Therefore, the Provider reasons that it can submit data to prove its SSI percentage was understated.

**Board Decision:**

The Board dismisses the Provider’s SSI Provider Specific issue related to how the Medicare Contractor computed the SSI percentage because it is duplicative of the SSI Systemic Errors issue.

The first aspect of the SSI Provider Specific issue is that the Provider disagrees with how the Medicare Contractor computed the SSI percentage that is used to determine the DSH percentage. The DSH/SSI issue concerns “whether the Medicare Contractor used the correct SSI percentage in the DSH calculation.”<sup>10</sup> The Provider’s legal basis for its SSI Provider Specific issue is that “the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i).”<sup>11</sup> The Provider contends that “its SSI percentage . . . was incorrectly computed . . . and it disagrees with the Medicare Contractor’s calculation of the computation of the DSH percentage set for that 42 C.F.R. § 412.106(b)(2)(i) of the Secretary’s regulations.”<sup>12</sup> This is duplicative of the Systemic Errors issue that the Provider transferred to group appeal.

The second aspect of the SSI Provider Specific issue is the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. The Board dismisses the Provider’s request to preserve its right to request realignment of the Supplemental Security Income (“SSI”) percentage from the federal fiscal year to its cost reporting period for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), to determine a Provider’s DSH percentage, “if a hospital prefers that CMS use its cost reporting data instead of the federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . .” Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes.

**Conclusion:**

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic errors issue and that there is no final determination with respect to the realignment portion of the issue. The SSI Provider Specific issue is hereby dismissed. As no issues remain pending, PRRB Case no. 15-2952 is closed and removed from the Board’s docket.

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<sup>9</sup> *Id.*

<sup>10</sup> *Id.* at 3, Issue 1.

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

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

A 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:**

5/20/2019

**X** Gregory H. Ziegler

Gregory H. Ziegler, CPA.

Board Member

Signed by: Gregory H. Ziegler -S

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Cahaba Safeguard Administrators  
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2803 Slater Road  
Suite 215  
Morrisville, NC 27560-2008

**RE: Wellmont Bristol Regional Medical Center**  
Provider No.: 44-0012  
FYE: 6/30/13  
PRRB Case No.:16-1471

Dear Mr. Ravindran and Mr. Lowe,

The Provider Reimbursement Review Board (“Board”) has reviewed the jurisdictional documents in case number 16-1471. The decision of the Board is set forth below.

**Background:**

The Provider appealed the amount of Medicare Reimbursement as determined by its Medicare Contractor in an Original Notice of Program Reimbursement (“NPR”) dated October 26, 2015. The Provider filed a timely appeal from the NPR on April 20, 2016 with eight issues. The Provider subsequently requested that six issues be transferred to group appeals including the SSI Systemic Errors issue to Case No. 17-0330GC.<sup>1</sup> The Provider withdrew the Medicaid Eligible Days issue.<sup>2</sup>

The remaining issue is the SSI Provider Specific issue: “Whether the Medicare Contractor used the correct SSI percentage in the Disproportionate Share Hospital Payment (“DSH”) calculation.”<sup>3</sup>

**Board Decision:**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2012), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is \$10,000

<sup>1</sup> See Model Form D- Request to Transfer Issue to Group Appeal (Dec. 7, 2016).

<sup>2</sup> See Notice of Withdrawal of Issue from Appeal (DSH Medicaid Eligible Days) (Mar. 10, 2018).

<sup>3</sup> See Model Form A- Individual Appeal Request (Apr. 20, 2016).

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

The Provider's individual appeal is based on the contention that the SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients entitled to SSI benefits in the Provider's DSH calculation. This is duplicative of the SSI Systemic Errors issue that was directly added to Common Issue Related Party ("CHRP") group, case number 17-0330GC: "Whether the Secretary properly calculated the Provider's DSH/SSI percentage."<sup>4</sup> Pursuant to PRRB Rule 4.6.1, "A Provider may not appeal an issue from a single determination in more than one appeal." Therefore, the Board finds that it does not have jurisdiction over this portion of the SSI Provider Specific issue.

The Board also finds that it does not have jurisdiction over the realignment portion of the Provider's issue statement and dismisses the Provider's request to preserve its right to request realignment of the Supplemental Security Income ("SSI") percentage from the federal fiscal year to its cost reporting period. Under 42 C.F.R. § 412.106(b)(3), to determine a Provider's DSH percentage, "if a hospital prefers that CMS use its cost reporting data instead of the federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes, therefore the Board finds that it does not have jurisdiction over this portion of the Provider's SSI Provider Specific issue.

**Conclusion:**

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue that was transferred to Case No. 17-0330GC and there is no final determination with which the Provider can be dissatisfied related to the realignment portion of the issue. The Board dismisses the SSI Provider Specific issue from this appeal.

No issues remain pending, therefore PRRB Case No. 16-1471 is hereby closed and removed from its docket.

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

**BOARD MEMBERS PARTICIPATING:**

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Charlotte F. Benson, CPA  
Gregory H. Ziegler, CPA, CPC-A  
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Susan A. Turner, Esq.

---

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

**FOR THE BOARD:**

5/20/2019

**X** Gregory H. Ziegler

Gregory H. Ziegler, CPA, CPC-A

Signed by: Gregory H. Ziegler -S

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





DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Healthcare Reimbursement Services, Inc.  
Ms. Corinna Goron  
President  
17101 Preston Road, Suite 220  
Dallas, TX 75248-1372

Noridian Healthcare Solutions, Inc.  
Ms. Lorraine Frewert  
Appeals Coordinator, JE Provider Audit  
P.O. Box 6782  
Fargo, ND 58108-6782

**RE: Encino Hospital Medical Center**  
Provider No.: 05-0158  
FYE: 12/31/2014  
PRRB Case No.: 18-0736

Dear Ms. Goron and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in case number 18-0736. The decision of the Board is set forth below.

**Background:**

The Provider has appealed a Notice of Program Reimbursement ("NPR") for FYE 09/08/2017. The Provider filed a timely appeal from the NPR dated 02/05/2018. The Provider appealed the following: (1) Whether the Medicare Administrative Contractor used the correct SSI percentage in the DSH calculation and (2) whether the Medicare Administrative Contractor properly excluded Medicaid Eligible Days from the DSH calculation. The Provider requested to withdraw the Medicaid eligible days issue on September 11, 2018. The Medicare Contractor did not raise a jurisdictional challenge.

**Board Decision:**

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is \$10,000 or more (or \$50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board dismisses the Provider's SSI Provider Specific Issue related to whether the Secretary properly calculated the Provider's Disproportionate Share Hospital/Supplemental Security Income percentage ("DSH") because it is duplicative of the SSI Systemic errors issue that was transferred to case number 16-1698GC. The Provider's appeal of this issue is based on the contention that the SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients entitled to SSI benefits in

the Provider’s DSH calculation. This is duplicative of the SSI Systemic Errors issue that was directly added to case number 16-1698GC. The Providers in this group contend that CMS has not properly calculated their SSI percentages because CMS failed to include all patients entitled to SSI benefits in the calculation. Pursuant to PRRB Rule 4.6.1, “A provider may not appeal an issue from a single determination in more than one appeal.” Therefore, the Board finds that the SSI Provider specific issue is duplicative of the issue the Provider is pursuing in the group appeal and dismisses the issue from this individual appeal.

In its SSI Provider Specific issue statement, the Provider asserts that it “preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider’s cost reporting period. Under 42 C.F.R. § 412.106(b)(3), “if a hospital prefers that CMS use its cost reporting data instead of the Federal Fiscal Year, it must furnish to CMS, through its intermediary, a written request.” Without a written request that goes to CMS, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied for purposes of an appeal. Therefore, the Board finds that the Provider has not established dissatisfaction with the realignment portion of its issue statement as required by 42 C.F.R. § 405.1835(a) and therefore dismisses that portion of the issue.

**Conclusion:**

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic errors issue transferred to a group and there is no final determination with respect to the realignment portion of the issue. PRRB Case No. 18-0736 is hereby closed and removed from the Board’s docket.

A 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.

5/20/2019

<b>X</b>	Gregory H. Ziegler
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Gregory H. Ziegler, CPA, CPC-A  
 Board Member  
 Signed by: Gregory H. Ziegler -S

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Delivery**

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

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

19-1865 Christian Hospital-Northeast-Northwest, Provider No. 26-0180, FYE 12/31/2007  
13-2952GC QRS BJC 2007 DSH Medicare Managed Care Part C Days Group  
14-0105GC QRS BJC 2008 DSH SSI Fraction Medicare Managed Care Part C Days Group  
14-0108GC QRS BJC 2008 DSH Medicaid Fraction Medicare Managed Care Part C Days Grp

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 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>

<sup>1</sup> This EJR request also included case numbers 14-1300GC and 14-1324GC. A response to the EJR request for those cases will be forthcoming in separate correspondence. In addition, case number 14-1148GC was also included in this EJR request. Because the case included a single participant, the group appeal was closed and an individual appeal, case number 19-1865, was established, This EJR request will include case number 19-1865 instead of case number 14-1148GC.

<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

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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.

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

<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 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>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.



### Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2007 and 2008.

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

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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.

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 required for a group appeal<sup>36</sup> and \$10,000 for an individual 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 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 request involve the 2007 and 2008 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>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.<sup>40</sup>

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

The Board finds that:

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

<sup>37</sup> See 42 C.F.R. § 405.1835(a)(2).

<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).

<sup>40</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 federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

- 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 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:

5/29/2019

X Clayton J. Nix

Clayton J. Nix, Esq.  
Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Byron Lamprecht (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  
Quality Reimbursement Services  
150 N. Santa Anita Avenue, Ste. 570A  
Arcadia, CA 91006

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

11-0816GC QRS BJC 2009 DSH SSI Medicare Part C Days Group  
14-1300GC QRS BJC 2009 DSH SSI Fraction Medicare Part C Days Group  
14-1324GC QRS BJC 2009 DSH Medicaid Fraction Medicare Part C Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ May 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>

**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> QRS submitted two EJR requests on May 1, 2019. The EJR request for case numbers 14-1300GC and 14-1324GC also included Case Nos. 13-2952GC, 14-0105GC, 14-0108GC, and 19-1865. A response to the EJR request for those cases (Case No. 13-2952GC, *et al.*) will be issued under separate cover. The EJR request that included Case No. 11-0816GC (an appeal from the Medicare Contractor’s failure to issue a final determination within 12 months of the receipt of the perfected cost report as permitted by 42 C.F.R. § 405.1835(a)(3)(ii) (2009)) also included Case Nos. 14-3934GC and 14-3835GC. A decision with respect to Case Nos. 14-3934GC and 14-3835GC will be issued under separate cover.

<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>

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<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>

<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 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.

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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' EJR Request at 1.

### Jurisdiction

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

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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.

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.

*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>37</sup> including documentation relating to jurisdiction. Similarly, the regulations governing group appeals specify that jurisdiction “may be raised at any time.”<sup>38</sup>

In Case Nos. 14-1300GC and 14-1324GC, the Board finds that it does not have jurisdiction over Participant 5 – Christian Hospital (Provider No. 26-0180, FYE 12/31/2009) because Christian Hospital 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 to appeal from a revised NPR. In this regard, 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

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

<sup>37</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>38</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.*”

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.

The Provider cites to three adjustments on its revised NPR from which it is appealing. However, each of these adjustments is to Medicaid eligible days on Worksheet S-3, which is also supported by the Provider's November 11, 2015 Reopening Request. In particular, the Provider's reopening request which indicated that the Provider was "requesting additional Medicaid days to be included in the Disproportionate Share calculation and in the IRF LIP calculation."<sup>39</sup> As the SSI fraction itself was not revised in the revised NPR, the Board finds that it does not have jurisdiction over Christian Hospital in either Case No. 14-1300GC or Case No. 14-1324GC. Therefore, the Board hereby dismisses Christian Hospital from these two appeals and from the EJR determination *as it relates to these two appeals*. The Board notes that Christian Hospital remains a participant in Case No. 11-0816GC based on its appeal of the failure of the Medicare contractor to timely issue an NPR pursuant to 42 C.F.R. § 405.1835(a)(3)(ii) (2011).

*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

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<sup>39</sup> Schedule of Providers in Case Nos. 14-1300GC and 14-1324GC at Tab 5D.

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>40</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 underlying remaining participants.

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

The appeals in these EJR request involve the 2009 cost 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 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>41</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>42</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.<sup>43</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 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>40</sup> See 42 C.F.R. § 405.1837.

<sup>41</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>42</sup> See 42 U.S.C. § 1395oo(f)(1).

<sup>43</sup> The Medicare Contractor, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR requests. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina I*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

- 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:

5/29/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS Gov. Health Adm'rs (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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410-786-2671

**Electronic Delivery**

James Ravindran  
Quality Reimbursement Services  
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Arcadia, CA 91006

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

14-0227GC QRS Wellmont HS 2007 DSH SSI Fraction Medicare Mngd Care Part C Days Group  
14-0239GC QRS Wellmont HS 2007 DSH Medicaid Fraction Medicare Mngd Care Part C Days Grp  
14-0409GC QRS Wellmont HS 2008 DSH SSI Fraction Medicare Managed Care Part C Days Group  
14-0411GC QRS Wellmont HS 2008 DSH Medicaid Fraction Medicare Mngd Care Part C Days Grp  
14-3097GC QRS Wellmont HS 2009 Medicaid Fraction Medicare Managed Care Pt. C Days Group  
14-3125GC QRS Wellmont HS 2009 DSH SSI Fraction Medicare Managed Care Part C Days Group  
14-3943GC QRS Wellmont HS 2010 DSH SSI Fraction Medicare Managed Care Pt. C Days Group  
14-3948GC QRS Wellmont HS 2010 DSH Medicaid Fraction Medicare Mngd Care Pt. C Days Grp

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 2, 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).

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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:

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<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).

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... *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>

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

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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).

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 that 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>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 2007-2010.

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 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.

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. 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 Providers which appealed revised NPRs have adjustments to Part C days as required by 42 C.F.R. § 405.1889. 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 request involve the 2007-2010 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.

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

<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).

Board's Decision Regarding the EJER 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 EJER 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. As this is the only issue in dispute in these cases, the Board hereby closes them.

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:

5/29/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Cecile Huggins, Palmetto GBS(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  
Quality Reimbursement Services  
150 N. Santa Anita Avenue  
Suite 570A  
Arcadia, CA 91006

**RE: *EJR Determination***

13-3954GC Mercy Health 2009 - 2010 Medicare Part C Days CIRP Group II

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 1, 2019 request for expedited judicial review ("EJR") for the appeal referenced above.<sup>1</sup> The Board's determination regarding EJR is set forth below.

**Issue in Dispute:**

The issue in this appeal 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>

**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>

<sup>1</sup> This EJR request also included case number 15-0434GC. A decision in that case will be sent under separate cover.

<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.*



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>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.)

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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>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>

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

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<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).

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 appeal within this EJR request have filed appeals involving fiscal year 2007, 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-disallowed cost,” pursuant to the Supreme Court’s reasoning set out in *Bethesda Hospital*

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

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

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

*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).

*A. Jurisdiction over Appeals of the Late Issuance of the NPRs*

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>37</sup> including documentation relating to jurisdiction. Similarly, the regulations governing group appeals specify that jurisdiction “may be raised at any time.”<sup>38</sup> To this end, Board Rule 20 requires the group representative in a group appeal to submit a Schedule of Providers with supporting jurisdictional documentation that demonstrates Board jurisdiction over the providers named in the group appeal. Board Rule 21 lays out the content requirements for that Schedule of Providers and supporting jurisdictional documentation.

The following ten Providers in Case No. 13-3954GC appealed from the MAC’s failure to issue a final determination within 12 months of the receipt of their respective cost report for the listed fiscal year (which is 6/30/2010 for each of these ten Providers):

- #1 Mercy Medical Center (Provider No. 04-0010), FYE 6/30/2010;
- #2 St Joseph’s Mercy Medical Center (Provider No. 04-0026), FYE 6/30/2010;
- #4 Mercy Hospital-Independence (Provider No. 17-0010), FYE 6/30/2010;
- #5 Mercy Health Center-Ft. Scott (Provider No. 17-0058), FYE 6/30/2010;
- #6 St. John’s Regional Medical Center (Provider No. 26-0001), FYE 6/30/2010;
- #8 St. John’s Mercy Hospital (Provider No. 26-0052), FYE 6/30/2010;
- #11 St. John’s Hospital-Lebanon (Provider No. 26-0059), FYE 6/30/2010;
- #14 St. John’s Hospital (Provider No. 26-0065), FYE 6/30/2010;
- #15 Mercy Health Center (Provider No. 37-0013), FYE 6/30/2010; and
- #16 Mercy Memorial Health Center (Provider No. 37-0047), FYE 6/30/2010.

The regulation, 42 C.F.R. § 405.1835(a)(3)(ii) (2013), permits providers to file an appeal with the Board based on the Medicare Contractor’s untimely issuance of a final determination:

If the intermediary determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the intermediary of the provider’s perfected cost report or amended cost report (as specified in 413.24(f) of

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<sup>37</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>38</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.”

this chapter), no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination. The date of receipt by the intermediary of the provider's perfected cost report is presumed to be the date the intermediary stamped "Received" unless it is shown by a preponderance of the evidence that the intermediary received the cost report on an earlier date.<sup>39</sup>

Further, § 405.1835(b) specifies, among other things, that a hearing request under § 405.1835(a)(3)(ii) "must include . . . [a] demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section."

In order to ensure compliance with 42 C.F.R. §§ 405.1835(a)(3)(ii) and 405.1835(b), Board Rule 7.4<sup>40</sup> instructs providers which appeal from the MAC's failure to timely issue a final determination that they must file the following documentation to support their entitlement to a Board hearing under § 405.1835(a)(3)(ii):

- 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 . . .

This requirement is reiterated in Board Rule 21.A dealing with the submission of the Schedule of Providers and associated jurisdictional documents. In this case, each of the ten Providers listed above failed to submit the information required by Board Rule 21.A to establish entitlement to a Board under 42 C.F.R. § 405.1835(a)(3)(ii). These ten Providers lacked documentation to support receipt of the "perfected cost report" which necessarily includes acceptance.<sup>41</sup>

Moreover, the Schedule of Providers for Case No. 13-3954GC does not contain any proof-of-delivery documentation confirming when the appeals for each of these ten

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<sup>39</sup> (Emphasis added.) CMS relocated this regulatory provision to 42 C.F.R. § 405.1835(c)(1) as part of the final rule published on August 22, 2014. See 79 Fed. Reg. 50350 (Aug. 22, 2014).

<sup>40</sup> The Board's Rules can be found on the internet at: [https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRules\\_03\\_01\\_2013.pdf](https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRules_03_01_2013.pdf).

<sup>41</sup>



Providers for FYE 6/30/2010 was filed with the Board. The Provider Representative admits on the Schedule of Providers that it "was unable to locate the delivery notification of the Model Form E" for each of these ten Providers for FYE 6/30/2010.

Since there is insufficient information to establish jurisdiction over their appeals under 42 C.F.R. § 405.1835(a)(3)(ii) (2013), the Board finds that it lacks jurisdiction over the following ten Providers for FYE 6/30/2010:

- #1 Mercy Medical Center (Provider No. 04-0010), FYE 6/30/2010;
- #2 St Joseph's Mercy Medical Center (Provider No. 04-0026), FYE 6/30/2010;
- #4 Mercy Hospital-Independence (Provider No. 17-0010), FYE 6/30/2010;
- #5 Mercy Health Center-Ft. Scott (Provider No. 17-0058), FYE 6/30/2010;
- #6 St. John's Regional Medical Center (Provider No. 26-0001), FYE 6/30/2010;
- #8 St. John's Mercy Hospital (Provider No. 26-0052), FYE 6/30/2010;
- #11 St. John's Hospital-Lebanon (Provider No. 26-0059), FYE 6/30/2010;
- #14 St. John's Hospital (Provider No. 26-0065), FYE 6/30/2010;
- #15 Mercy Health Center (Provider No. 37-0013), FYE 6/30/2010; and
- #16 Mercy Memorial Health Center (Provider No. 37-0047), FYE 6/30/2010.

The Board hereby dismisses these ten Providers from the appeal *as it relates to their FYE June 30, 2010*. Since jurisdiction over these ten Providers for FYE 6/30/2010 is a prerequisite to granting a request for EJR, the Board denies their request for EJR *as it relates to their FYE June 30, 2010*.

**B. *Jurisdiction and Request for EJR for 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. The appeals of revised NPRs have adjustments to the Part C days as required by 42 C.F.R. § 405.1889 for Board jurisdiction. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.<sup>42</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 this EJR request involve the 2007, 2009 and 2010 cost reporting periods. Thus, the appealed cost reportings period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final

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

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.<sup>45</sup>

### Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It does not have jurisdiction over the following ten participants for FYE 6/30/2010 and denies their request for EJR as it relates to their FYE June 30, 2010:
  - #1 Mercy Medical Center (Provider No. 04-0010), FYE 6/30/2010,
  - #2 St Joseph's Mercy Medical Center (Provider No. 04-0026), FYE 6/30/2010,
  - #4 Mercy Hospital-Independence (Provider No. 17-0010), FYE 6/30/2010,
  - #5 Mercy Health Center-Ft. Scott (Provider No. 17-0058), FYE 6/30/2010,
  - #6 St. John's Regional Medical Center (Provider No. 26-0001), FYE 6/30/2010,
  - #8 St. John's Mercy Hospital (Provider No. 26-0052), FYE 6/30/2010,
  - #11 St. John's Hospital-Lebanon (Provider No. 26-0059), FYE 6/30/2010,
  - #14 St. John's Hospital (Provider No. 26-0065), FYE 6/30/2010,
  - #15 Mercy Health Center (Provider No. 37-0013), FYE 6/30/2010, and
  - #16 Mercy Memorial Health Center (Provider No. 37-0047), FYE 6/30/2010;
- 2) It has jurisdiction over the matter for the subject years and that the remaining participants in this group appeal 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;

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<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).

<sup>45</sup> 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 federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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

Board Members Participating:

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

FOR THE BOARD:

5/29/2019

 Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedule of Providers

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

**Electronic Mail**

James Ravindran  
Quality Reimbursement Services  
150 N. Santa Anita Avenue  
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Arcadia, CA 91006

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

14-3224GC QRS WVUHS 2008 DSH Medicaid Fraction Medicare Mngd Care Part C Days Grp  
14-3227GC QRS WVUHS 2008 DSH SSI Fraction Medicare Mngd Care Part C Days Group  
17-0333GC QRS Wellmont HS 2013 DSH SSI Fraction Medicare Mngd Care Part C Days Grp  
17-0332GC QRS Wellmont HS 2013 DSH Medicaid Fraction Medicare Mngd Care Part C Days Grp

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ May 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>

**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:

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).

<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>

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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

<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.

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 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

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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).



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 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.

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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.”).

<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 2008 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

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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.

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 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 request involve the 2008 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;

<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).

- 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 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:

5/29/2019

X Clayton J. Nix

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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)  
Laurie Polson, Palmetto GBA c/o 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 Mail**

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

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

16-0089GC HRS DCH 2010 DSH SSI Fraction Medicare Managed Care Part C Days Group  
16-0090GC HRS DCH 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days Grp

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 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>

**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>

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>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.)

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

### 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>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.

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

<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).



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.

### **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.

<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.”).

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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.

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

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

<sup>33</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>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.

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, remaining providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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

The appeals in this EJR request involve the 2010 cost 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 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.

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<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).

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

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 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 remaining Providers' request for EJ 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:

5/29/2019

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  
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**Electronic Delivery**

James Ravindran  
Quality Reimbursement Services  
150 N. Santa Anita Avenue  
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Arcadia, CA 91006

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

14-3834GC QRS BJC 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group  
14-3835GC QRS BJC 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days Grp

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (“Board”) has reviewed the Providers’ May 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>

**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>

<sup>1</sup> This EJR request also included case number 11-0816GC. A response to that EJR request will be forthcoming in separate correspondence.

<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.*

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>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:

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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>

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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.

<sup>15</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>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:

... *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

<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.



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

<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).

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.

### **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>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.

### Jurisdiction

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

<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.

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.

*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>37</sup> including documentation relating to jurisdiction. Similarly, the regulations governing group appeals specify that jurisdiction “may be raised at any time.”<sup>38</sup>

In Case Nos. 14-1300GC and 14-1324GC, the Board finds that it does not have jurisdiction over Participant 5 – Christian Hospital (Provider No. 26-0180, FYE 12/31/2009) because Christian Hospital 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 to appeal from a revised NPR. In this regard, 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

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

<sup>37</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>38</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.”

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.

The Provider cites to three adjustments on its revised NPR from which it is appealing. However, each of these adjustments is to Medicaid eligible days on Worksheet S-3, which is also supported by the Provider's November 11, 2015 Reopening Request. In particular, the Provider's reopening request which indicated that the Provider was "requesting additional Medicaid days to be included in the Disproportionate Share calculation and in the IRF LIP calculation."<sup>39</sup> As the SSI fraction itself was not revised in the revised NPR, the Board finds that it does not have jurisdiction over Christian Hospital in either Case No. 14-1300GC or Case No. 14-1324GC. Therefore, the Board hereby dismisses Christian Hospital from these two appeals and from the EJR determination *as it relates to these two appeals*. The Board notes that Christian Hospital remains a participant in Case No. 11-0816GC based on its appeal of the failure of the Medicare contractor to timely issue an NPR pursuant to 42 C.F.R. § 405.1835(a)(3)(ii) (2011).

#### *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

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<sup>39</sup> Schedule of Providers in Case Nos. 14-1300GC and 14-1324GC at Tab 5D.

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>40</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 underlying remaining participants.

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

The appeals in these EJR request involve the 2009 cost 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>41</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>42</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.<sup>43</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 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>40</sup> See 42 C.F.R. § 405.1837.

<sup>41</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>42</sup> See 42 U.S.C. § 1395oo(f)(1).

<sup>43</sup> The Medicare Contractor, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR requests. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina I*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

- 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:

5/29/2019

X Clayton J. Nix

Clayton J. Nix, Esq.  
Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS Gov. Health Adm'rs (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  
Quality Reimbursement Services  
150 N. Santa Anita Ave., Suite 570A  
Arcadia, CA 91006

**RE: *EJR Determination***

13-3253GC QRS WFHC 2007 DSH Medicare Managed Care Part C Days Group  
13-3281GC QRS WFHC 2010 DSH SSI Fraction Medicare Mngd Care Part C Days Group  
13-3284GC QRS WFHC 2010 DSH Medicaid Fraction Medicare Mngd Care Part C Days Group  
14-4099GC QRS WFHC 2011 DSH SSI Fraction Medicare Mngd Care Part C Days Group  
14-4101GC QRS WFHC 2011 DSH Medicaid Fraction Medicare Mngd Care Part C Days CIRP  
15-1017GC QRS WFHC 2012 SSI Fraction Medicare Managed Care Part C Days Group  
15-1018GC QRS WFHC 2012 DSH Medicaid Fraction Medicare Mngd Care Part C Days Group  
16-1835GC QRS WFHC 2013 DSH Medicaid Fraction Medicare Mngd Care Part C Days Group  
16-1838GC QRS WFHC 2013 DSH SSI Fraction Medicare Mngd Care Part C Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 13, 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>

**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> The May 13, 2019 Request for EJR also included Case No. 10-0924GC. The Board will address the EJR request for this group under separate cover.

<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

<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).

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 including HMO days in the SSI/Medicare percentage [of the DSH adjustment].<sup>15</sup>

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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.

<sup>15</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>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:

. . . *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*

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<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.

*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 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

<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).

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 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*

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

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

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

*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 required for a group appeal.<sup>36</sup> Although case number 13-3253GC was established as group

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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. § 405.1837.

appal, it only have a single participant<sup>37</sup> and the Board is electing to treat the case as an individual appeal. The participant in case number 13-3253GC has met the \$10,000 threshold for the year under appeal for Board jurisdiction over individual appeals.<sup>38</sup> The appeal was 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 request involve the 2007 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>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 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;

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<sup>37</sup> In case number 10-0924GC, the appeal contains a single participant that appealed two different fiscal years. Case number 13-3253GC contains a single participant.

<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> In Case No. 10-0924GC, 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 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.

- 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.

FOR THE BOARD:

5/31/2019

**X** Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Danene Hartley, NGS(Electronic Mail w/Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)





DEPARTMENT OF HEALTH & HUMAN SERVICES

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**RE: EJR Determination**

14-3303G QRS 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days Group  
14-3854GC QRS HHC 2009 DSH SSI Fraction Medicare Managed Care Part C Days Group  
14-3855GC QRS HHC 2009 DSH Medicaid Fraction Medicare Managed Care Part C Days Group  
15-1155GC QRS HHC 2008 DSH SSI Fraction Medicare Managed Care Part C Days Group  
15-1156GC QRS HHC 2008 DSH Medicaid Fraction Medicare Managed Care Part C Days Group  
18-1795GC Hartford Health CY 2005 DSH SSI Fraction Medicare Mngd Care Part C Days Group  
18-1796GC Hartford Health CY 2005 DSH Medicaid Fraction Medicare Mngd Care Part C Days Grp

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 13, 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>

<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

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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:

<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>

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

<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).

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.

### **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 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, 2008, 2009 and 2011.

<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.

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 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>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.

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 for Case Nos. 14-3303G, 15-1155GC, and 15-1156GC.<sup>35</sup> Although the remaining cases were established as group appeals, they only have a single participant and the Board is electing to treat the cases as individual appeals.<sup>36</sup> The remaining cases have met the \$10,000 threshold for Board jurisdiction over individual appeals.<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 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 request involve the 2005, 2008, 2009 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 participants in these 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;

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

<sup>36</sup> Case Nos. 14-3854GC; 14-3855GC; 18-1795GC; and 18-1796GC.

<sup>37</sup> See 42 C.F.R. § 405.1835.

<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).



- 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.

FOR THE BOARD:

5/31/2019

 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)  
Pam VanAresdale, NGS (Electronic Mail w/Schedules of Providers)  
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)



Provider Reimbursement Review Board  
1508 Woodlawn Drive, Suite 100  
Baltimore, MD 21207  
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**Electronic Mail**

Isaac Blumberg  
Blumberg Ribner, Inc.  
11400 W. Olympic Blvd.  
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Los Angeles, CA 90064-1582

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

18-1790G Blumberg Ribner Indep. Hosps. 2005 Medicare HMO Part C Days-Medicaid Fraction  
18-1791G Blumberg Ribner Indep. Hosps. 2005 Medicare HMO Part C Days-Medicare Fraction

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 10, 2019 request for expedited judicial review ("EJR") (received May 13, 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>

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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 . . . .  
(emphasis added)

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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).

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 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

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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

<sup>9</sup> 42 C.F.R. § 412.106(b)(2)-(3).

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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>

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.<sup>13</sup>

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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*

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<sup>15</sup> 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

*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 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)

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<sup>16</sup> 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

<sup>17</sup> 69 Fed. Reg. at 49,099.

<sup>18</sup> *Id.*

<sup>19</sup> 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

<sup>20</sup> 72 Fed. Reg. at 47411.

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. 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 regulation 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

<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 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.

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 appeals involving fiscal year 2005.

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 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

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<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.).

<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.



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 jurisdiction over the remaining participants involved with the instant EJR request is governed by the decision in *Bethesda*. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal<sup>32</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 this EJR request involve the 2005 cost reporting period. 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>33</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>34</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 Providers are entitled to a hearing before the Board;

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<sup>32</sup> See 42 C.F.R. § 405.1837.

<sup>33</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>34</sup> See 42 U.S.C. § 1395oo(f)(1).

- 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) (2008) 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) (2008) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the remaining Providers' requests for EJRs 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 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:

5/31/2019

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)



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 Mail**

Isaac Blumberg  
Blumberg Ribner, Inc.  
315 South Beverly Drive  
Suite 505  
Beverly Hills, CA 90212-1925

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

18-1389GC    SSM Health 2012 Medicare HMO Part C Days-Medicare Fraction Group  
18-1393GC    SSM Health 2012 Medicare HMO Part C Days-Medicaid Fraction Group

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 10, 2019 request for expedited judicial review ("EJR") (received May 13, 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>

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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 . . . .  
(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>

<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).

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. (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

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<sup>10</sup> 42 C.F.R. § 412.106(b)(4).

<sup>11</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>12</sup>

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

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<sup>12</sup> 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).

<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).

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 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>

<sup>17</sup> 69 Fed. Reg. at 49,099.

<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).

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 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>23</sup> However, the Secretary has not acquiesced to that decision. 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 regulation 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 year 2012.

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

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<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 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>24</sup> 863 F.3d 937 (D.C. Cir. 2017).

<sup>25</sup> *Id.* at 943.

<sup>26</sup> *Id.* at 943-945.



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*.<sup>27</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>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.

The Board has determined that jurisdiction over the remaining 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

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<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.).

<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.

a group appeal<sup>32</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 this EJR request involve the 2012 cost reporting period. 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>33</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>34</sup> Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.<sup>35</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 Providers 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

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<sup>32</sup> See 42 C.F.R. § 405.1837.

<sup>33</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>34</sup> See 42 U.S.C. § 1395oo(f)(1).

<sup>35</sup> 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 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.

- 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 remaining Providers' requests 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 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:

5/31/2019

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)