DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
Cleveland Regional Medical Center (Prov. No. 34-0021)
FYE 12/31/2012
Case No. 16-0481

Dear Mr. Ravindran,

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

Pertinent Facts:

On December 18, 2015, the Board received Provider's Individual Appeal Request appealing their June 24, 2015 Notice of Program Reimbursement ("NPR") for fiscal year ending December 31, 2012. The initial appeal contained the eight (8) following issues:

1. DSH/SSI (Provider Specific)
2. DSH/SSI (Systemic Errors)[1]
3. DSH Payment- SSI Fraction/Medicare Managed Care Part C Days[2]
4. DSH Payment- SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days and No-Pay Part A Days)[3]
5. DSH Payment- Medicaid Eligible Days
6. DSH Payment- Medicaid Fraction/Medicare Managed Care Part C Days[4]
7. DSH Payment- Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[5]
8. Outlier Payments- Fixed Loss Threshold[6]

[1] Issue 2 was transferred to Group Case No. 15-3319GC on August 17, 2016. *See* Exhibit C-2.
[2] Issue 3 was transferred to Group Case No. 15-3316GC on August 17, 2016. *See* Exhibit C-2.
[3] Issue 4 was transferred to Group Case No. 15-3318GC on August 17, 2016. *See* Exhibit C-2.
[4] Issue 6 was transferred to Group Case No. 15-3317GC on August 17, 2016. *See* Exhibit C-2.
[5] Issue 7 was transferred to Group Case No. 15-3315GC on August 17, 2016. *See* Exhibit C-2.
[6] Issue 8 was transferred to Group Case No. 15-1646GC on August 17, 2016. *See* Exhibit C-2

Issues 2, 3, 4, 6, 7, and 8 were transferred to Group Case Nos. 15-3319GC, 15-3316GC, 15-3318GC, 15-3317GC, 15-3315GC, and 15-1646GC respectively. Accordingly, Issues 1 and 5 are the only remaining issues.

In its appeal request, the Provider summarizes Issue 1, the DSH/SSI (Provider Specific) issue, as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[7]

Similarly, the Provider described Issue 2, the DSH/SSI (Systemic Errors) issue, which has been transferred to Case Number 15-3319GC, as follows:

> The Providers contend that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.

[7] Individual Appeal Request, Issue 1.

> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Paid days vs. Eligible Days
> 3. Not in agreement with provider's records
> 4. Fundamental problems in the SSI percentage calculation
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[8]

On April 28, 2022, the Provider submitted its Final Position Paper, and the following is the Provider's ***complete*** position on Issue 1 for Calculation of the SSI Percentage:

> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Department of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' [sic] records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[9]

---

[8] *Id* at Issue 2.
[9] Provider's Final Position Paper at 8-9 (Apr. 28, 2022).

On May 18, 2018, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor which argued that the Board lacks jurisdiction over Issue 1 (the DSH/SSI (Provider Specific) issue) because it is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue), which was transferred to Case 15-3319GC.

Board Decision:

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

The Board finds that it does not have jurisdiction over Issue 1, the DSH/SSI (Provider Specific) issue. This jurisdictional analysis of Issue 1 has two components:

1. The Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage.

2. The Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

A. Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI (Systemic Errors) issue that was transferred to Group Case No. 15-3319GC.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was transferred to Case No. 15-3319GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[10] The Provider's legal basis for this aspect of Issue 1 is simply 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)."[11] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12] Issue 2, transferred to the group under Case No. 15-3319GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of

[10] Individual Appeal Request, Issue 1.
[11] *Id.*
[12] *Id.*

factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 2, currently in Case No. 15-3319GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 15-3319GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[13] Provider is incorrect in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider's Final Position Paper ("FPP") has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 15-3319GC.

To this end, the Board staff also reviewed the Provider's FPP to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from Issue 2. Accordingly, the Board finds that the Provider's FPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions."[14] Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its FPP and include *all* exhibits. The Provider stated in its appeal that it was "seeking *SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[15] However, the Provider simply states again it is "seeking [MEDPAR data] from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage" but fails to give any update on those efforts since it filed its appeal on December 18, 2015, in direct violation of Board Rule 25.2.2:

> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available.

[13] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[14] (Emphasis added.)
[15] (Emphasis added.)

> Once the documents become available, promptly forward them to the Board and the opposing party.

Accordingly, the Board must find that Issues 1 and 2, which was transferred to Group Case No. 15-3319GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. In the alternative, the Board would dismiss Issue 1 due to the Provider's failure to properly brief the issue in its FPP in compliance with Board Rules.

B. Second Aspect of Issue 1

The Board finds that the second aspect of the DSH SSI (Provider Specific) issue involves the Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." The Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. Accordingly, the second aspect of Issue 1 is dismissed from the appeal.

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety from this appeal. Case No. 16-0481 remains open given that another issue, DSH Payment – Medicaid Eligible Days (Issue 5), remains pending.

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

For the Board:

5/2/2022

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nina Marsden, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Ste 1600
Los Angeles, CA 90067

RE: ***EJR Determination***
MHS 2008 Dual Eligible CIRP Group
Case No. 14-3909GC

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 28, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal. The decision of the Board to *deny* EJR is set forth below.

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

By letter dated April 25, 2022, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group case consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On March 22, 2022, subsequent to the submission of the EJR request in this appeal, the Board notified you of the relevance of Alert 19 to the EJR request. In particular, the Board notified you of the following:

> As the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under" the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b).

In this regard, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "***only if*** . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days ***after*** finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete."[1] Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[2]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. The issuance of this determination completes the Board jurisdictional review process and the Board is concurrently issuing its determination on the EJR request as the Board is familiar with the legal issues raised in the EJR request and has previously issued similar EJR determinations for those legal issues.

Issue in Dispute

The two providers used to establish this CIRP group are: (1) Long Beach Memorial Medical Center ("Memorial"); and (2) Community Hospital of Long Beach ("Community") (collectively hereinafter "Founding Providers"). The Founding Providers initially filed transfer requests to join the CIRP group under Case No. 09-2332GC entitled "MHS 10/1/2004-2007 Dual Eligible CIRP Group." However, by letter dated August 12, 2014, the Board found that the requested transfers were outside the fiscal years approved for Case No. 09-2332GC, and it denied expansion of that CIRP group.[3] As a result of these rulings, the Board, therein, took the

---

[1] (Emphasis added.)
[2] (Emphasis added.)
[3] Board Letter re: Requests to Transfer Providers into MHS 10/1/2004-2007 Dual Eligible CIRP Group, Case No. 09-2332GC (Aug. 12, 2014). The Board notes that Case No. 09-2332GC is still open and pending before the Board. Case No. 09-2332GC originally included DSH dual eligible days for discharges prior to October 1, 2004 but, in October 2013, the Board bifurcated those pre-October 1, 2004 days into Case No. 13-3960GC. Indeed, Case No. 09-2332GC was formed on or about September 14, 2009 and appears to be a bifurcation from (or, at a minimum, related to) Case No. 09-2176GC entitled "MHS 1996 – 2003 DSH Dual Eligibles CIRP Group," which was established via an appeal request filed on August 26, 2009 that included certain FY 2004 providers that ultimately ended up in Case

alterative action of establishing the instant single-year CIRP group covering 2008 under Case No. 14-3909GC.[4]

As no group issue statement was filed to establish the instant CIRP group (and the providers were not transferring from a group), the issue transferred by the Founding Providers from their respective individual appeals, governs the group issue statement. Here, the Founding Providers each had the same issue statement in their individual appeals for the issue that they transferred to the instant CIRP group. That issue statement reads as follows:

> ISSUE: Dual eligible days *excluded from the Medicaid **and** SSI ratios*.
>
> BRIEF DESCRIPTION: Whether the MAC utilized the appropriate Medicaid and/or SSI ratios in the calculation of the DSH and LIP adjustments as *dual eligible days were excluded from **both** ratios*.
>
> . . . .
>
> BASIS FOR APPEAL: 42 C.F.R. § 412.106(b), 412.320 and 412.624(e)
>
> Dual eligible days are patient days associated with those patients who were ***not** included in the SSI denominator by CMS' design* as they were not directly billed to Medicare and did not flow through the [MEDPAR] system. ***These days*** are disallowed as "Medicare eligible" by the MAC from the Medicaid numerator. Hence, *neither the Medicaid fraction nor the Medicare fraction captured the days associated with this indigent population.*

No. 09-2332GC. As explained in CMS Ruling 1498-R, CMS' policy prior to October 1, 2004 was to exclude no-pay Part-A days (including the subset associated with dual eligible) from both the Medicare and Medicaid fractions:

> Hospitals have also filed DSH appeals to the PRRB challenging the **exclusion** from the DPP of non-covered inpatient hospital days for patients entitled to Medicare Part A, including appeals of days for which the patient's Part A hospital benefits were exhausted. Under CMS' original policy, inpatient days were included in the numerator of the DSH SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the SSI fraction. *See, e.g.*, 42 C.F.R. § 412.106(b)(2)(i) (2003). CMS' original policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were **excluded** from the numerator of the DSH Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days in its Medicare cost report). *See* 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004) ("FY 2005 IPPS final rule").

CMS Ruling 1498-R at 7-8 (Apr. 28, 2010) (bold emphasis added).

[4] *Id.* The Board notes that, as part of this correspondence, the Board also denied other transfer requests relating to other years and the Board similarly established MHS CIRP groups for these other years.

> Dual eligible days were excluded from the Medicaid fraction for a variety of reasons. By way of example, some dual eligible days are associated with patients who are eligible for Medicaid by have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL) v. Blue Cross and Blue Shield Association . . . , PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held:
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. [citations omitted].
>
> Thus, in accordance with the Board's holding in Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days". . . .[5]

In contrast, the EJR request for the CIRP group frames the legal question as follows:

> The Group Appeal challenges the regulation and policy of [CMS], promulgated as part of the FY 2005 IPPS Final Rule, to count exhausted or otherwise non-covered days for patients eligible for Medicare *in the Medicare/SSI fraction* and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction, as adopted and applied by CMS for purposes of calculating the Hospitals' Medicare [DSH] payments during their respective fiscal years included in the Group Appeal.[6]

The following excerpts from this EJR request shed additional light on the nature of this legal question:

- "As Section III below shows, the Hospitals are challenging the validity of CMS's regulation and policy to count exhausted or otherwise non-covered days for patients eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction."[7]

- "Part A exhausted or noncovered days should, for dually-eligible patients, be ***included*** *in the numerator of the Medicaid fraction,* ***and excluded*** *from the Medicare/SSI fraction*, because, by definition, those days relate to patients who were not 'entitled to' Medicare Part A benefits 'for such days' when the services were

[5] *E.g.*, PRRB Case 13-3145, Individual Appeal Request, Issue 7 (Aug. 21, 2013) (emphasis added).
[6] Request for Expedited Judicial Review, 1-2 (Mar. 28, 2022) ("EJR Request").
[7] *Id.* at 2 (emphasis added).

provided. Part A exhausted days and noncovered days should be excluded from the Medicare/SSI fraction for the same reason."[8]

- "Accordingly, CMS's regulation and policy requiring *including* Part A exhausted and other noncovered days in the Medicare/SSI fraction, ***and*** *excluding* such days from the numerator of the Medicaid fraction for dually-eligible patients, are 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,' 5 U.S.C. §706(2)(A), 'in excess of statutory jurisdiction, authority, or limitations, or short of statutory right,' id. §706(2)(C), and/or were not promulgated in accordance with applicable notice and comment requirements under, 42 U.S.C. §1395hh and/or 5 U.S.C. §553."[9]

Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[14] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[15] The DPP is defined as the sum of two fractions expressed as percentages.[16] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which

[8] *Id*. at 5 (emphasis added).
[9] *Id*. at 6 (emphasis added.)
[10] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[11] *Id*.
[12] *See* 42 U.S.C. § 1395ww(d)(5).
[13] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[14] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[15] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[16] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[17]

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[19]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[20]

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

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

---

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

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[23] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[24] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[25]

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

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

---

[23] *Id.*
[24] *Id.*
[25] *Id.* at 27207-27208.
[26] *Id.* at 27207-08.
[27] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[28] 68 Fed. Reg. at 27208.
[29] *Id.*
[30] *Id.*
[31] *Id.*

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[32] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[33]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[34] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently *misstated* our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[35]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the*

[32] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[33] *Id.*
[34] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[35] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).

> *days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[36]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[37] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[38] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[39]

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

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

---

[36] *Id.* at 49099 (emphasis added).
[37] *Id.*
[38] *See id.* at 49099, 49246.
[39] (Emphasis added.)
[40] (Emphasis added.)

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[41]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[42] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[43]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[44] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[45] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[46] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[47] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit");

---

[41] *Id.*
[42] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).
[43] (Citations omitted and emphasis added.)
[44] 317 F. Supp. 3d 168 (D.D.C. 2018).
[45] *Id.* at 172.
[46] *Id.* at 190.
[47] *Id.* at 194.

however, the D.C. Circuit later dismissed it.[48] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[49] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[50] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[51]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[52] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[53] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[54] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[55] and that the regulation is procedurally invalid.[56]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[57] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[58] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[59] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in

[48] *See* 2019 WL 668282.
[49] 718 F.3d 914 (2013).
[50] 657 F.3d 1 (D.C. Cir. 2011).
[51] 718 F.3d at 920.
[52] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[53] *Id.* at 1141.
[54] *Id.*
[55] *Id.* at 1162.
[56] *Id.* at 1163
[57] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[58] *Id.* at 884.
[59] *Id.* at 884.

Legacy Emanuel Hospital and Health Center v. Shalala ("*Legacy Emanuel*")[60] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[61] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[62] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[63] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[64] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

Providers' Position

Issue Outlined in the EJR Request for the CIRP Group

The Providers in the CIRP group requested EJR to challenge the inclusion of certain Part A non-covered (*e.g.*, Part A exhausted) patient days in the Medicare fraction of the DSH calculation. The Providers argue that CMS has been inconsistent with the treatment of days for Medicare inpatients who have exhausted their Part A benefits or whose days have otherwise not been paid (Part A exhausted and other non-covered days). They note that, while historically these days were not counted in the Medicare fraction, CMS proposed in the FY 2004 IPPS Proposed Rule to count the days for patients who were dually-eligible in the numerator of the Medicaid fraction. However, CMS did not enact this proposal. Rather, in the FY 2005 IPPS Final Rule, CMS finalized the opposite policy: Part A exhausted and non-covered days would be counted in the Medicare fraction, and these days would be excluded from dual-eligible days in the Medicaid fraction numerator. The Providers assert that this policy change resulted in those exhausted non-

[60] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[61] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[62] *Id.* at 886.
[63] *Id.*
[64] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

covered days associated with dually eligible patients being excluded from the Medicaid fraction's numerator and only potentially being included in the Medicare fraction's numerator.[65]

The Providers contend that the policy adopted in the FY 2005 IPPS Final Rule and the associated regulatory changes were substantively and/or procedurally invalid. They claim that these no-pay Part A days should be included in the numerator of the Medicaid fraction (for the subset of those days associated with dually-eligible patients) and excluded in full from the Medicare fraction (both the numerator and denominator) because these days relate to patients who were not "entitled to" Part A benefits "for such days" when the services were provided. They state that CMS' policy deserves no deference. They contend that CMS misstated both its current and proposed policies in its FY 2004 and 2005 rulemaking, failed to provide adequate notice and opportunity for comment, and has interpreted "entitled to benefits under [Medicare Part A]" for purposes of the DSH fractions in a manner inconsistent with the statute and precedent. They note that the Ninth Circuit's decision in *Empire Health Foundation v. Azar* vacated the regulation at issue.[66] The Providers maintain EJR is appropriate because the regulation was held to be invalid and is being reviewed by the Supreme Court, and because the Board lacks the authority to review the validity of a regulation.[67]

Issue Appealed by the CIRP Group

As previously noted, this CIRP group was created after the Founding Providers sought to transfer Dual Eligible days issues from several individual appeals and the group issue for this CIRP group was set based on the issue transferred by the Founding Providers.[68] In the individual appeals, the stated issue is simply stated as "Dual eligible days excluded from the Medicaid ***and*** SSI Ratios."[69] The "Basis for Appeal," thus, appears to describe CMS' pre-October 1, 2004 policy (*i.e.*, the policy in effect prior to the FY 2005 IPPS Final Rule) to exclude no-pay Part A days (including days associated with patients who were dual eligibles) from ***both*** the Medicare fraction and the Medicaid fraction.[70] Indeed, the appealed issue states that it pertains to those days that "were not included in the SSI [*i.e.*, Medicare] denominator by design" (*i.e.*, no pay dual eligible days) and were "disallowed . . . from the Medicaid numerator. Hence, ***neither*** *the Medicaid fraction* ***nor*** *the Medicare fraction captured the days associated with this indigent population.*"[71] In support of their position, the Providers cite to *Edgewater Med. Ctr. v. Blue Cross and Blue Shield Ass'n*,[72] a Board decision issued in 2000 which involved a provider's 1990 fiscal year and clearly predates the dual eligible days policy enacted in FY 2005 IPPS Final Rule, which is the subject of the instant EJR Request.

---

[65] EJR Request at 4-5.
[66] *Id.* at 6 (citing to 958 F.3d 873 (9th Cir. 2020).
[67] *Id.* at 5-6.
[68] Board Letter re: Requests to Transfer Providers into MHS 10/1/2004-2007 Dual Eligible CIRP Group, Case No. 09-2332GC (Aug. 12, 2014).
[69] (Emphasis added.)
[70] *See* CMS Ruling 1498-R2 at 3 (Apr. 22, 2015); CMS Ruling 1498-R at 7-8 (Apr. 28, 2010). The relationship of this appeal to other MHS CIRP cases with pre-2004 fiscal years challenging CMS' policy in effect prior to the changes made in the FY 2005 IPPS Final Rule supports this conclusion. *See supra* note 3.
[71] (Emphasis added).
[72] PRRB Dec. 2000-D44 (Apr. 7, 2000).

Decision of the Board

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

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [73]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[74]

For an issue to be added to an existing appeal, the request for addition must comply with the same requirements for requesting a Board hearing in an initial appeal.[75] When the underlying individual appeals were filed, the Board Rules (Mar. 1, 2013) required Providers to, for each issue under appeal, provide the basis for dissatisfaction with its final determination. With regard to identifying the issue, Providers were required to provide an issue statement that described the adjustment, ***why the adjustment was incorrect***, and how the payment should be determined differently.[76] Similarly, the regulation at 42 C.F.R. § 405.1835(b) (2013) stated:

> (b) *Contents of request for a Board hearing*. The provider's request for *a Board hearing* must be submitted in writing to the Board, and the request **must include the elements** described in paragraphs (b)(1) through (b)(4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraphs (b)(1), (b)(2), or (b)(3) of this section, **the Board may**

[73] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[74] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[75] 42 C.F.R. § 405.1835(e).
[76] PRRB Rule 7 (Mar. 1, 2013) (emphasis added). *See also* Board Rule 8 (stating "Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7." (emphasis added)).

> **dismiss with prejudice** the appeal, or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section . . . .
>
> (2) An explanation (for **each** specific item at issue, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for **each** disputed item (or where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to the underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimburse-ment or payment sought for the item.

Failure to meet these requirements permits the Board to dismiss the issue with prejudice or take any other remedial action it considers appropriate.[77] A request to add an additional issue is timely made if received by the Board no later than 240 days after the date of a final determination.[78]

The Board finds that the Providers in this CIRP group have appealed only those "dual eligible days" that it alleges were excluded from ***both*** the Medicare fraction ***and*** the Medicare fraction (as reflected in the CMS policy predating the FY 2005 IPPS Final Rule).[79] The issue statements used to form the group do not refer to no-pay Part A days such as exhausted days or Medicare secondary payor ("MSP") days. In this regard, the Board notes that a reference to "dual eligible days" for a hospital's fiscal year is clearly different than no-pay Part A days where the

---

[77] 42 C.F.R. § 405.1835(b).
[78] 42 C.F.R. § 405.1835(c)(3) (2013).
[79] The issue statement associated with the individual appeals that established the group appeal clearly defines the term "dual eligible days" as used therein as those days that "were not included in the SSI [*i.e.*, Medicare] denominator by CMS' design" where "***[t]hese*** *days* were [also] disallowed as 'Medicare eligible' by the MAC from the Medicaid numerator." (Emphasis added.) The relationship of this appeal to other MHS CIRP cases appealing this same class of days and challenging CMS' policy in effect prior to the changes made in the FY 2005 IPPS Final Rule support this conclusion. *See supra* note 3. Similarly, the only authority cited by the Providers in their issue statement is the Board's 2000 decision in *Edgewater* which, as discussed *supra*, clearly involved and applied the pre-October 1, 2004 policy.

underlying patients associated with those days across a fiscal year largely were not Medicaid eligible and only a subset of those patients were Medicaid eligible.

In contrast, the EJR request concerns the FY 2005 IPPS Final Rule and challenges CMS' policy set forth therein to count *all* no-pay Part A days in the Medicare fraction effective for discharges on or after October 1, 2004 and seeks to include the subset of those days for which the underlying patients were also Medicaid eligible in the numerator of the Medicaid fraction. Any challenge to that policy would necessarily be a separate and distinct issue from the one appealed in the issue statement for this CIRP group. As such, the Board finds that the Providers' EJR request attempts to add issues to this CIRP group, namely: (1) the exclusion of all no-pay part A days from the Medicare fraction; and (2) the inclusion of the ***subset*** of those days, for which the underlying patients were also Medicaid eligible (*i.e.*, were dually eligible), in the numerator of the Medicaid fraction. However, 42 C.F.R. § 405.1837(f)(1) makes clear that issues may *not* be added to a group appeal after the group hearing request is filed. As such, the Board finds that it lacks jurisdiction in these appeals over the ***specific*** issue sought in its EJR Request because it was not included in the original appeals, and, since jurisdiction is a prerequisite to granting EJR, the Board hereby ***denies*** the EJR Request for Case No. 14-3909GC.

Finally, the Board notes that one requirement for Board jurisdiction over a group is that the group have, in the aggregate, at least $50,000 or more in controversy as specified in 42 C.F.R. § 405.1840(a). Here, each of the Providers participating the instant CIRP group did not include a specific amount in controversy for the issue that they transferred to the instant CIRP group.[80] Thus, for purpose of demonstrating that they met the minimum $50,000 amount in controversy for purposes of forming a group, the Providers included in the final Schedule of Providers a calculation of the estimated amount in controversy for each Provider. Each of those calculations is dated March 18, 2022 and, less than 4 weeks later, the Providers filed the instant EJR request on April 13, 2022. Thus, it is clear that these estimates were prepared in anticipation of the instant EJR request and a review of these estimates demonstrates that they relate *only* to the issue for which the Providers seek EJR (as opposed to the issue that was originally appealed and used to form the group). Specifically, each of these estimates shows the "[p]otential impact of using covered days (per CMS) with the decrease in SSI days added to Medi-Cal." For example, the estimated amount in controversy included for Memorial at Tab 2E of the Schedule of Providers where Memorial's DSH payment would increase by an estimated $103,688 due to: (1) a decrease in the Medicare fraction from 14.89 percent to 14.84 percent by *removing* no pay Part A days so that only "covered days" remain; and (2) an increase the number of Medi-Cal Eligible days from 18,799 to 19,034 as used in the numerator of the Medicaid fraction. Thus, these estimates clearly show a decrease to the Medicare fraction and an increase to the Medicaid fraction. In contrast, the issue statement used to form the group relates *only* to the class of dual eligible days that were excluded from ***both*** the Medicare and Medicaid fractions and, as such, the Medicare fraction would never be decreased under the group issue.[81] Based on the above

[80] The individual appeals for each of these providers included multiple issues and, rather than giving an amount in controversy for each issue, each provider relied on the issues in the aggregate to meet the minimum $10,000 amount in controversy required for an individual appeal. *See* 42 C.F.R. § 405.1839(a)(2).

[81] Moreover, the Board notes that the CMS policy in effect *during the time at issue in this CIRP group* was to count all no-pay Part A days in the Medicare fraction (including those associated with patients who were also Medicaid

findings, it is clear that the *fully-formed* group does not have any estimated impact on the group issue for which it was formed.

Pursuant to 42 C.F.R. § 405.1837(a)(3), the amount in controversy for a group is determined in accordance with § 405.1839, which states, in pertinent part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under §405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000.
>
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues.
>
> (A) A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in §405.1837(a)(2) of this subpart).
>
> (B) The single issue that is common to each provider may exist over different cost reporting periods.
>
> (ii) For purposes of satisfying the amount in controversy requirement, a provider may appeal multiple cost reporting periods and different providers in the group may appeal different cost reporting periods.

In addition, § 405.1837(e)(2) makes clear that the Board may consider dismissing a group appeal hearing request for failure to meet that requirement once the group is *fully formed*.

Here, it is clear that the CIRP group is ***fully formed*** and that the Providers have failed to demonstrate that they meet the $50,000 amount in controversy requirement *for the issue covered by the group*. Rather, they have attempted to add an issue to the group and alleged an amount in controversy for this added issue. As previously noted, adding issues to group appeals is prohibited by regulation. As the group is fully formed and the providers have failed to establish

---

eligible). Accordingly, if an amount in controversy had been calculated for the class of days *covered by the group issue statement* (*i.e.*, those dual eligible days that were excluded from ***both*** the Medicare *and* Medicaid fractions), it would appear that the amount in controversy for this CIRP group would be close to zero (*i.e.*, below the minimum $50,000 threshold) since, under that policy, there would be no dual eligible days excluded from both the Medicare and Medicaid fractions during the years at issue. To the extent any dual eligible days were, ***in fact***, excluded from both fractions (as alleged but yet contrary to that policy), then that would be a factual issue and would presumably be similar to the systemic data match issues raised in the *Baystate* litigation. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, Adm'r Dec. (May 11, 2006); *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008).

they meet the amount in controversy *for the issue appealed by the group*, the Board hereby dismisses the group appeal pursuant to its authority under 42 C.F.R. §§ 405.1837(e)(2) and 42 C.F.R. § 405.1868(b)(2).

Further, the facts that a group appeal may contain only one issue and that the EJR request, along with estimated amounts in controversy, were submitted on an issue other than the one for which the group appeal was established, the Board must conclude that the Providers have abandoned the original group issue. This serves as an alternate, and independent, basis for dismissal.[82]

* * * * *

In summary, the Board denies the EJR request and dismisses the CIRP group. Accordingly, the Board closes this CIRP group and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

FOR THE BOARD:

5/4/2022

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS

[82] This is analogous to Board Rules governing position papers which specify that "If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Board Rule 25.3 (Nov. 2021). Further Board Rule 41.2 specifies:

> The Board may dismiss a case or an issue on its own motion:
>
> - If it has a reasonable basis to believe that the issues have been fully settled or abandoned:
> - Upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868); . . . .

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nina Marsden, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Ste 1600
Los Angeles, CA 90067

RE: ***EJR Determination***
MemorialCare CY 2015 Medicare Part A Days CIRP Group
Case Nos. 19-0118GC(A), 19-0118GC(B)

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 28, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal involving MemorialCare. The decision of the Board is set forth below.

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

By letter dated April 25, 2022, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group case consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On March 22, 2022, subsequent to the submission of the EJR request in this appeal, the Board notified you of the relevance of Alert 19 to the EJR request. In particular, the Board notified you of the following:

> As the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under" the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b).

In this regard, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "***only if*** . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days ***after*** finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete."[1] Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[2]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. The issuance of this determination completes the Board jurisdictional review process and the Board is concurrently issuing its determination on the EJR request as the Board is familiar with the legal issues raised in the EJR request and has previously issued similar EJR determinations for those legal issues.

II. Issue in Dispute

The Dual Eligible days issue in this CIRP group appeal is framed by the Providers, as follows:

> DSH - SSI and Medicaid Fractions - Medicare Part A Days
>
> Whether the Provider's DSH payment for the period under appeal was improperly low because of the failure to properly account for inpatient days attributable to patients where there was no Medicare coverage or where Medicare did not make Part A payment, including, but not limited to, Part A exhausted days and Medicare Secondary Payer ("MSP") days. This issue relates both to the Medicare/SSI fraction and the Medicaid fraction.

[1] (Emphasis added.)
[2] (Emphasis added.)

> In accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), days relating to hospital inpatients who, at the time of service, were "eligible for medical assistance under a State plan approved under title XIX," but "not entitled to benefits under [Medicare] Part A" are to be included in the numerator of the Medicaid fraction. Dually-eligible Part A exhausted days, MSP days, and other similar days should be included in the numerator of the Medicaid fraction and excluded from the Medicare fraction because, by definition, those days relate to patients who were not "entitled to" Medicare Part A benefits when services were provided. Non-dually eligible Part A exhausted days, MSP days, and other similar days should be excluded from the Medicare fraction for the same reason.
>
> The Provider's DSH payment should be recalculated to ensure that (a) all dually-eligible Part A exhausted days, MSP days, and other similar days are included in the numerator of the Medicaid fraction and excluded from the Medicare/SSI fraction and (b) all non-dually-eligible Part A exhausted days, MSP days, and other similar days are excluded from the Medicare/SSI fraction. [3]

In the Providers' request for EJR, they frame the legal question as follows:

> The Group Appeal challenges the regulation and policy of [CMS], promulgated as part of the FY 2005 IPPS Final Rule, *to count* exhausted or otherwise *non-covered days for patients eligible for Medicare in the Medicare/SSI fraction* ***and*** *not, where the patient is dually eligible for Medicaid, in the Medicaid fraction*, as adopted and applied by CMS for purposes of calculating the Hospitals' Medicare [DSH] payments during their respective fiscal years included in the Group Appeal.[4]

The following excerpts shed additional light on the nature of this legal question:

- "As Section III below shows, the Hospitals are challenging the validity of CMS's regulation and policy to count exhausted or otherwise non-covered days for patients eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction."[5]

- "Part A exhausted or noncovered days should, for dually-eligible patients, be ***included*** *in the numerator of the Medicaid fraction*, ***and excluded*** *from the Medicare/SSI fraction*, because, by definition, those days relate to patients who were

[3] Group Issue Statement (Oct. 25, 2018).
[4] Request for Expedited Judicial Review, 1-2 (Mar. 28, 2022) ("EJR Request").
[5] *Id.* at 2 (emphasis added).

not 'entitled to' Medicare Part A benefits 'for such days' when the services were provided. Part A exhausted days and noncovered days should be excluded from the Medicare/SSI fraction for the same reason."[6]

- "Accordingly, CMS's regulation and policy requiring *including* Part A exhausted and other noncovered days in the Medicare/SSI fraction, ***and*** *excluding* such days from the numerator of the Medicaid fraction for dually-eligible patients, are 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,' 5 U.S.C. §706(2)(A), 'in excess of statutory jurisdiction, authority, or limitations, or short of statutory right,' id. §706(2)(C), and/or were not promulgated in accordance with applicable notice and comment requirements under, 42 U.S.C. §1395hh and/or 5 U.S.C. §553."[7]

The Board takes administrative notice that it has generally required the formation of two separate groups for the Exhausted Part A Days issue when the issue statement for the appeal requests not just exclusion of no-pay Part A days from the Medicare fraction (aka the SSI fraction) but also the inclusion, in the Medicaid fraction, of the subset of those days for which the underlying patient was also Medicaid eligible (*i.e.*, was a dual eligible) because, in that instance, there are two legal issues.[8] Specifically, in these instances, the Board has usually required bifurcation of the appeal to create two CIRP groups. First, one CIRP group for the "SSI Fraction/Dual Eligible Days" issue, which challenges the inclusion of noncovered Medicare days in the SSI fraction (as mandated by the regulatory revisions made by the FY 2005 IPPS Final Rule). Second, a CIRP group for the "Medicaid Fraction/Dual Eligible Days" issue, which alleges that, if the days at issue are excluded from the SSI fraction (*i.e.*, following a successful reversal of the regulatory revisions made by the FY 2005 IPPS Final Rule), then the subset of days that are associated with Medicaid eligible patients should be included in the numerator of the Medicaid fraction (as opposed to simply being excluded from the SSI fraction and the numerator of the Medicaid fraction as was done prior to the FY 2005 IPPS Final Rule).[9]

The Board notes that the group issue statement in this case contains a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions. The statute and regulations governing group appeals specifically note that a provider

---

[6] *Id.* at 5 (emphasis added).
[7] *Id.* at 6 (emphasis added.)
[8] The Board also takes administrative notice that, when processing EJR requests on these two issues, it is correcting any limited situations where the Board may have previously consolidated these two issues in error.
[9] The point of Rule 8 was to confirm that, at a minimum, Part A exhausted and noncovered days must be considered separately from other DSH components issues such as Medicare Part C days. Thus, the reference in Board Rule 8 to dual eligible Medicare Part A exhausted and noncovered days as a common example of a component issue in DSH does not mean that an appeal challenging that component could not itself have multiple issues. In this regard, the Board takes administrative notice that many appeals of this DSH issue simply seek to overturn the policy change made in the FY 2005 IPPS Final Rule to revert back to the prior policy, *i.e.*, excluding no-pay Part A days from both the SSI fraction and Medicaid fraction. The Board considers this example to be one issue which is different than what the Providers are seeking in this CIRP group. Again the Board must determine on a case-by-case basis because providers appealing a subject matter may make disparate legal arguments and/or seek disparate relief.

has a right to a Board hearing as part of a group appeal with other providers "***only if*** . . . [t]he matter at issue in the group appeal involves a ***single*** question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group[.]"[10] Further, "[w]hen the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."[11]

As discussed below in Section V.B, since the Board has determined jurisdiction is proper for all participants for both issues, and for the sake of judicial economy, the Board is hereby bifurcating this CIRP Group Appeal into the following cases, as reflected in the attached Schedules of Providers:

- 19-0118GC(A): MemorialCare CY 2015 Medicare Part A Days CIRP Group/SSI Fraction
- 19-0118GC(B): MemorialCare CY 2015 Medicare Part A Days CIRP Group/Medicaid Fraction[12]

III. Statutory and Regulatory Background

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[13] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[14]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[15] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[16]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[17] As a proxy for utilization by low-income patients, the DPP determines a hospital's

---

[10] 42 C.F.R. § 405.1837(a)(2). *See also* 42 U.S.C. 1395oo(b) (noting that a group appeal is proper "***only if*** the matters in controversy involve a common question of fact or interpretation of law or regulations . . .").
[11] 42 C.F.R. § 405.1837(f)(2)(ii).
[12] As these cases have the same record up to this point and there will be no further proceedings before the Board following this decision, the Board has opted for purposes of administrative efficiency not to create a separate case number within OH-CDMS at this time. Should additional proceedings before the Board occur in these cases on remand to the Board, then the Board would do so at that time, as appropriate and relevant.
[13] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[14] *Id.*
[15] *See* 42 U.S.C. § 1395ww(d)(5).
[16] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[17] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).

qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[18] The DPP is defined as the sum of two fractions expressed as percentages.[19] 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 . . . .[20]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[21]

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.[22]

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.[23]

---

[18] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[19] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[20] (Emphasis added.)
[21] 42 C.F.R. § 412.106(b)(2)-(3).
[22] (Emphasis added.)
[23] 42 C.F.R. § 412.106(b)(4).

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

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[24] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[25]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[26] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[27] The Secretary then summarized his policy by stating that "our *current* policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[28]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[29] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[30] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted:

> The degree of difficulty depends on the data provided by the States, which may vary from one State to the next. Some States identify all dual-eligible beneficiaries in their lists of Medicaid patient days provided to the hospitals, while in other States the [Medicare contractor] must

[24] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.* at 27207-27208 (emphasis added).
[29] *Id.* at 27207-08.
[30] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.

> identify patient days attributable to dual-eligible beneficiaries by matching Medicare Part A bills with the list of Medicaid patients provided by the State. The latter case is problematic when Medicare Part A coverage is exhausted because no Medicare Part A bill may be submitted for these patients. Thus, the [Medicare contractor] has no data by which to readily verify any adjustment for these cases in the Medicaid data provided by the hospital. Currently, the [Medicare contractors] are reliant on the hospitals to identify the days attributable to dual-eligible beneficiaries so these days can be ***excluded*** *from the Medicaid patient days count*.[31]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[32] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[33] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [34] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[35]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[36] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[37]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[38] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had

[31] 68 Fed. Reg. at 27208 (emphasis added).
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[37] *Id.*
[38] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

"inadvertently misstated" its then current policy on the treatment of dual eligible beneficiaries in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[39]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[40]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[41] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[42] Prior to this revision, § 412.106(b)(2) (2004) had stated:

---

[39] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[40] *Id.* at 49099 (emphasis added).
[41] *Id.*
[42] *See id.* at 49099, 49246.

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[43]

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

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that--*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[44]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[45]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[46] This is highlighted in CMS Ruling 1498-R as follows:

---

[43] (Emphasis added.)
[44] (Emphasis added.)
[45] *Id.*
[46] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[47]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[48] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[49] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule was *not* procedurally defective.[50] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[51] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[52] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[53] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[54] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[55]

---

[47] (Citations omitted and emphasis added.)
[48] 317 F. Supp. 3d 168 (D.D.C. 2018).
[49] *Id.* at 172.
[50] *Id.* at 190.
[51] *Id.* at 194.
[52] *See* 2019 WL 668282.
[53] 718 F.3d 914 (2013).
[54] 657 F.3d 1 (D.C. Cir. 2011).
[55] 718 F.3d at 920.

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[56] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[57] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[58] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[59] and that the regulation is procedurally invalid.[60]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[61] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[62] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[63] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[64] wherein the Ninth Circuit considered the meaning of the words "entitled" and "eligible" in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[65] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[66] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary

[56] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[57] *Id.* at 1141.
[58] *Id.*
[59] *Id.* at 1162.
[60] *Id.* at 1163
[61] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[62] *Id.* at 884.
[63] *Id.* at 884.
[64] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[65] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[66] *Id.* at 886.

interpretation of that phrase is substantively invalid pursuant to APA."[67] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[68] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

IV. Providers' Position

The Providers in the CIRP group requested EJR to challenge the inclusion of certain Part A non-covered (*e.g.*, Part A exhausted) patient days in the Medicare fraction of the DSH calculation. The Providers argue that CMS has been inconsistent with the treatment of days for Medicare inpatients who have exhausted their Part A benefits or whose days have otherwise not been paid (Part A exhausted and other non-covered days). They note that, while historically these days were not counted in the Medicare fraction, CMS proposed in the FY 2004 IPPS Proposed Rule to count the days for patients who were dually-eligible in the numerator of the Medicaid fraction. However, CMS did not enact this proposal. Rather, in the FY 2005 IPPS Final Rule, CMS finalized the opposite policy: Part A exhausted and non-covered days would be counted in the Medicare fraction, and these days would be excluded from dual-eligible days in the Medicaid fraction numerator. The Providers assert that this policy change resulted in those exhausted non-covered days associated with dually eligible patients being excluded from the Medicaid fraction's numerator and only potentially being included in the Medicare fraction's numerator.[69]

The Providers contend that the policy adopted in the FY 2005 IPPS Final Rule and the associated regulatory changes were substantively and/or procedurally invalid. They claim that these no-pay Part A days should be included in the numerator of the Medicaid fraction (for the subset of those days associated with dually-eligible patients) and excluded in full from the Medicare fraction (both the numerator and denominator) because these days relate to patients who were not "entitled to" Part A benefits "for such days" when the services were provided. They state that CMS' policy deserves no deference. They contend that CMS misstated both its current and proposed policies in its FY 2004 and 2005 rulemaking, failed to provide adequate notice and opportunity for comment, and has interpreted "entitled to benefits under [Medicare Part A]" for purposes of the DSH fractions in a manner inconsistent with the statute and precedent. They

[67] *Id.*
[68] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).
[69] EJR Request at 4-5.

note that the Ninth Circuit's decision in *Empire Health Foundation v. Azar* vacated the regulation at issue.[70] The Providers maintain EJR is appropriate because the regulation was held to be invalid and is being reviewed by the Supreme Court, and because the Board lacks the authority to review the validity of a regulation.[71]

V. Decision of the Board

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

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

All of the Providers in this CIRP group appeal have FYEs prior to December 31, 2016.

1. Statutory and Regulatory Background

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[72] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[73]

On August 21, 2008, new regulations governing the Board became effective.[74] Among these new regulations was 42 C.F.R. § 405.1835(a)(1)(ii) which added the requirement for cost report periods ending on or after December 31, 2008 that providers who were self-disallowing specific items to do so by following the procedures for filing a cost report under protest.

---

[70] *Id.* at 6 (citing to 958 F.3d 873 (9th Cir. 2020).
[71] *Id.* at 5-6.
[72] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[73] *Bethesda*, 108 S. Ct. at 1258-59.
[74] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

This new regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[75] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[76]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which addresses dissatisfaction with Medicare Contractor determinations for cost report periods which end on or after December 31, 2008 but 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) are no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

2. *Jurisdiction over Case Nos. 19-0118GC(A) and 19-0118GC(B) and the Underlying Participants*

On April 1, 2022, the Medicare contractor filed a response to the Providers' EJR Request. They noted that there are no jurisdictional impediments, but that the issue in these group appeals contain multiple components (challenging aspects of the SSI Ratio and Medicaid Fraction). Since group cases must contain one single issue, these cases do not comply with the Board's Rules and EJR is not appropriate until the cases have been bifurcated.

The Provider replied the Medicare Contractor's response on April 13, 2022 arguing that it is appropriate to keep the cases as one issue and states:

> Contrary to FSS' assertion, bifurcation is not warranted here, and EJR is appropriate at this time. In each of the above-referenced EJR requests, the Providers are seeking EJR on the Part A exhausted or non-covered days issue, that is, whether the Provider's DSH payment was improperly low because of the failure to properly account for inpatient days attributable to patients where there was no Medicare coverage or where Medicare did not make Part A payment, in both the Medicare SSI fraction and the Medicaid fraction. PRRB Rule 8 ("Framing Issues for Adjustments Involving Multiple Components") expressly recognizes this as single issue with multiple components, described

[75] 201 F. Supp. 3d 131 (D.D.C. 2016).
[76] *Id.* at 142.

> as "Dual eligible Medicare Part A/Medicaid, which is often referred to as dual eligible Medicare Part A Exhausted and Noncovered Days." Accordingly, FSS' position that each of the appeals should be bifurcated because it contains multiple DSH components (i.e., the SSI ratio and Medicaid fraction) is contrary to the PRRB rules. FSS' assertion that the cases should be bifurcated "as has historically been the case" unnecessarily focuses on form over substance and ignores that the PRRB currently recognizes this as a single issue with multiple components.

As discussed in Section II and in Section V.B below, the Board agrees with the Medicare Contractor that there are two legal issues and has bifurcated this original case into Case Nos. 19-0118GC(A) and 19 0118GC(B) in compliance with 42 C.F.R. §§ 405.1837(b)(1) and 405.1837(f)(2)(ii).[77] Further, the Board has determined that the Exhausted Part A/Dual Eligible Days issues, in the instant CIRP group case, are governed by CMS Ruling CMS-1727-R since they are challenging the FY 2005 IPPS Final Rule and that Board review of the issues is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[78] The appeals were timely filed and no jurisdictional impediments have been identified for the remaining participants. Finally, the Board notes that each Provider was either directly added to this CIRP group appeal, or specifically included a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions in their respective individual appeals. Based on the foregoing, the Board finds that it has jurisdiction for Case Nos. 19-0118GC(A) and 19-0118GC(B).

B. Board's Analysis of the Appealed Issue

42 C.F.R. § 405.1867 specifies that "[i]n exercising its authority to conduct proceedings under this subpart, the Board ***must*** *comply with* all the provisions of Title XVIII of the Act and *regulations issued thereunder* . . . ."[79] Consequently the Board finds that it is bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Providers, namely: (1) invalidating the FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issue and calendar year under appeal in this case.

In making this finding, the Board notes that, as described above, the Providers maintain in their EJR request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated (either procedurally or substantively) and that, instead of

---

[77] 42 C.F.R. § 405.1837(f)(2)(ii) states: "When the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."
[78] *See* 42 C.F.R. § 405.1837.
[79] (Emphasis added.)

reverting back to the prior policy of the Secretary under which such days were counted in neither fraction, those days should be counted in the numerator of the Medicaid fraction to the extent they involve patients who were also Medicaid eligible.

As evidenced, by the 9th Circuit's decision in *Empire*, the invalidation of the DSH no-pay Part A days policy (as finalized in the FY 2005 IPPS Final Rule) does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that the 9th Circuit's decision in *Empire* only reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i) under which no-pay Part A days were counted in neither the Medicare fraction nor the Medicaid fraction.

Moreover, it is clear that the situation in the instant case is not as simple as the one presented in *Allina Health Servs. v. Sebelius* ("*Allina*").[80] In *Allina*, the 9th Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in Allina stated: "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[81]

In contrast, this case involves no-pay Part A days and the subset of no-pay Part A days associated with dual eligibles. It is clear that the *class of patients* who are dually eligible do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, with respect to this *patient class*, any days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction and included in the Medicaid fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits).[82] To this end, the Providers are asserting that only in *certain* ***no-pay*** Part A situations that involve a dual eligible beneficiary (*e.g.*, exhausted benefits and MSP) must the days associated with this class of patients be excluded from the SSI fraction and included in the Medicaid fraction.

Similarly, the class of patients who have Medicare Part A includes dual eligibles and that, with respect to this larger patient class, any days associated with them may not be excluded *in toto* (*i.e.*, it is undisputed that some Part A patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits). Significantly, under the Providers' desired interpretation of the DSH statute, any days associated with no-Pay Part A days for which the beneficiary was *not* Medicaid eligible (*i.e.*, the patient was not a dual eligible) would not be counted in either the Medicare or Medicaid fraction.

Accordingly, the Board disagrees with the Providers' assertion that exclusion of days associated with no-pay Part A situations where the underlying patient is a dual eligible *automatically* means

---

[80] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[81] *Id.* (emphasis added).
[82] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).

such days must be counted in the Medicaid fraction. In support of its position, the Board refers to: (1) the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*");[83] and (2) CMS Ruling 1498-R2, wherein multiple possible treatments of no-pay dual eligible days are discussed and wherein CMS reconfirms that its policy prior to October 1, 2004 was to exclude all no-pay Part A days from the Medicare and Medicaid fractions even where the underlying patient was also eligible for Medicaid, stating:

> Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 CFR 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098).[84]

Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[85] Thus, in the event the Supreme Court upholds the 9th Circuit's decision in *Empire*, the Providers would be arguing that the CMS' prior policy of excluding from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.[86]

Accordingly, the Board continues to maintain that the legal argument in the set of CIRP groups for the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the legal argument in the set of CIRP groups for the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the subset of no-pay part A days that involve patients who are also eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating this EJR request as a consolidated

---

[83] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients
[84] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.
[85] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater*").
[86] *See also supra* note 9.

request involving the common issues underlying Case Nos. 19-0118GC(A) and 19-0118GC(B) as set forth in Section II.

C. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Providers in Case Nos. 19-0118GC(A) and 19-0118GC(B) are entitled to a hearing before the Board;

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

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

4) It is without the authority to decide the legal question in Case No. 19-0118GC(A) of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid and the legal question in Case No. 19-0118GC(B) of what policy should then apply, namely whether to exclude or include such no-pay Part A days which involve a dual eligible from the Medicaid fraction if all no-pay Part A days are excluded from the Medicare fraction.

Accordingly, the Board concludes that the questions in Finding No. 4 properly fall 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. Further, the Board closes these group cases and removes them from the Board's docket.[87] The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

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

For the Board:

5/4/2022

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Scott Berends, FSS

[87] In granting EJR and closing each of these group cases, the Board notes a group case can only have one legal issue pursuant to 42 C.F.R. §§ 405.1837(a)(2), (f)(2) and that, following full formation of the group, the Providers have not identified any other pending issue(s) outside of their EJR request.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nina Marsden, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Ste 1600
Los Angeles, CA 90067

RE: ***EJR Determination***
MemorialCare CY 2016 Medicare Part A Days CIRP Group
Case Nos. Case 19-1555GC(A), 19-1555GC(B)

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 28, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal involving MemorialCare. The decision of the Board is set forth below.

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

By letter dated April 25, 2022, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group case consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On March 22, 2022, subsequent to the submission of the EJR request in this appeal, the Board notified you of the relevance of Alert 19 to the EJR request. In particular, the Board notified you of the following:

> As the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under" the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b).

In this regard, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "***only if*** . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days ***after*** finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete."[1] Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[2]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. The issuance of this determination completes the Board jurisdictional review process and the Board is concurrently issuing its determination on the EJR request as the Board is familiar with the legal issues raised in the EJR request and has previously issued similar EJR determinations for those legal issues.

II. Issue in Dispute

The Dual Eligible days issue in this CIRP group appeal by the Providers is framed as follows:

> DSH - SSI and Medicaid Fractions - Medicare Part A Days
>
> Whether the Provider's DSH payment for the period under appeal was improperly low because of the failure to properly account for inpatient days attributable to patients where there was no Medicare coverage or where Medicare did not make Part A payment, including, but not limited to, Part A exhausted days and Medicare Secondary Payer ("MSP") days. This issue relates both to the Medicare/SSI fraction and the Medicaid fraction.

[1] (Emphasis added.)
[2] (Emphasis added.)

> In accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), days relating to hospital inpatients who, at the time of service, were "eligible for medical assistance under a State plan approved under title XIX," but "not entitled to benefits under [Medicare] Part A" are to be included in the numerator of the Medicaid fraction. Dually-eligible Part A exhausted days, MSP days, and other similar days should be included in the numerator of the Medicaid fraction and excluded from the Medicare fraction because, by definition, those days relate to patients who were not "entitled to" Medicare Part A benefits when services were provided. Non-dually eligible Part A exhausted days, MSP days, and other similar days should be excluded from the Medicare fraction for the same reason.
>
> The Provider's DSH payment should be recalculated to ensure that (a) all dually-eligible Part A exhausted days, MSP days, and other similar days are included in the numerator of the Medicaid fraction and excluded from the Medicare/SSI fraction and (b) all non-dually-eligible Part A exhausted days, MSP days, and other similar days are excluded from the Medicare/SSI fraction. [3]

In the Providers' request for EJR, they frame the legal question as follows:

> The Group Appeal challenges the regulation and policy of [CMS], promulgated as part of the FY 2005 IPPS Final Rule, *to count exhausted or otherwise non-covered days for patients eligible for Medicare in the Medicare/SSI fraction* ***and*** *not, where the patient is dually eligible for Medicaid, in the Medicaid fraction*, as adopted and applied by CMS for purposes of calculating the Hospitals' Medicare [DSH] payments during their respective fiscal years included in the Group Appeal.[4]

The following excerpts shed additional light on the nature of this legal question:

- "As Section III below shows, the Hospitals are challenging the validity of CMS's regulation and policy to count exhausted or otherwise non-covered days for patients eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction."[5]

- "Part A exhausted or noncovered days should, for dually-eligible patients, be ***included*** *in the numerator of the Medicaid fraction,* ***and excluded*** *from the Medicare/SSI fraction*, because, by definition, those days relate to patients who were not 'entitled to' Medicare Part A benefits 'for such days' when the services were

[3] Group Issue Statement (Mar. 28, 2019).
[4] Request for Expedited Judicial Review, 1-2 (Mar. 28, 2022) ("EJR Request") (emphasis added).
[5] *Id.* at 2 (emphasis added).

provided. Part A exhausted days and noncovered days should be excluded from the Medicare/SSI fraction for the same reason."[6]

- "Accordingly, CMS's regulation and policy requiring *including* Part A exhausted and other noncovered days in the Medicare/SSI fraction, ***and*** *excluding* such days from the numerator of the Medicaid fraction for dually-eligible patients, are 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,' 5 U.S.C. §706(2)(A), 'in excess of statutory jurisdiction, authority, or limitations, or short of statutory right,' id. §706(2)(C), and/or were not promulgated in accordance with applicable notice and comment requirements under, 42 U.S.C. §1395hh and/or 5 U.S.C. §553."[7]

The Board takes administrative notice that it has generally required the formation of two separate groups for the Exhausted Part A Days issue when the issue statement for the appeal requests not just exclusion of no-pay Part A days from the Medicare fraction (aka the SSI fraction) but also the inclusion, in the Medicaid fraction, of the subset of those days for which the underlying patient was also Medicaid eligible (*i.e.*, was a dual eligible) because, in that instance, there are two legal issues.[8] Specifically, in these instances, the Board has usually required bifurcation of the appeal to create two CIRP groups. First, one CIRP group for the "SSI Fraction/Dual Eligible Days" issue, which challenges the inclusion of noncovered Medicare days in the SSI fraction (as mandated by the regulatory revisions made by the FY 2005 IPPS Final Rule). Second, a CIRP group for the "Medicaid Fraction/Dual Eligible Days" issue, which alleges that, if the days at issue are excluded from the SSI fraction (*i.e.*, following a successful reversal of the regulatory revisions made by the FY 2005 IPPS Final Rule), then the subset of days that are associated with Medicaid eligible patients should be included in the numerator of the Medicaid fraction (as opposed to simply being excluded from the SSI fraction and the numerator of the Medicaid fraction as was done prior to the FY 2005 IPPS Final Rule).[9]

The Board notes that the group issue statement in this case contains a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions. The statute and regulations governing group appeals specifically note that a provider has a right to a Board hearing as part of a group appeal with other providers "***only if*** . . . [t]he matter at issue in the group appeal involves a ***single*** question of fact or interpretation of law,

---

[6] *Id.* at 5 (emphasis added).
[7] *Id.* at 6 (emphasis added.)
[8] The Board also takes administrative notice that, when processing EJR requests on these two issues, it is correcting any limited situations where the Board may have previously consolidated these two issues in error.
[9] The point of Rule 8 was to confirm that, at a minimum, Part A exhausted and noncovered days must be considered separately from other DSH components issues such as Medicare Part C days. Thus, the reference in Board Rule 8 to dual eligible Medicare Part A exhausted and noncovered days as a common example of a component issue in DSH does not mean that an appeal challenging that component could not itself have multiple issues. In this regard, the Board takes administrative notice that many appeals of this DSH issue simply seek to overturn the policy change made in the FY 2005 IPPS Final Rule to revert back to the prior policy, *i.e.*, excluding no-pay Part A days from both the SSI fraction and Medicaid fraction. The Board considers this example to be one issue which is different than what the Providers are seeking in this CIRP group. Again the Board must determine on a case-by-case basis because providers appealing a subject matter may make disparate legal arguments and/or seek disparate relief.

regulations, or CMS Rulings that is common to each provider in the group[.]"[10] Further, "[w]hen the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."[11]

As discussed below in Section V.B, since the Board has determined jurisdiction is proper for all participants for both issues, and for the sake of judicial economy, the Board is hereby bifurcating this CIRP Group Appeal into the following cases, as reflected in the attached Schedules of Providers:

- 19-1555GC(A): MemorialCare CY 2016 Medicare Part A Days CIRP Group/SSI Fraction
- 19-1555GC(B): MemorialCare CY 2016 Medicare Part A Days CIRP Group/Medicaid Fraction[12]

III. Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[13] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[14]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[15] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[16]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[17] 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

---

[10] 42 C.F.R. § 405.1837(a)(2). *See also* 42 U.S.C. 1395oo(b) (noting that a group appeal is proper "***only if*** the matters in controversy involve a common question of fact or interpretation of law or regulations . . .").
[11] 42 C.F.R. § 405.1837(f)(2)(ii).
[12] As these cases have the same record up to this point and there will be no further proceedings before the Board following this decision, the Board has opted for purposes of administrative efficiency not to create a separate case number within OH-CDMS at this time. Should additional proceedings before the Board occur in these cases on remand to the Board, then the Board would do so at that time, as appropriate and relevant.
[13] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[14] *Id.*
[15] *See* 42 U.S.C. § 1395ww(d)(5).
[16] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[17] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).

hospital.[18] The DPP is defined as the sum of two fractions expressed as percentages.[19] 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 . . . .[20]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[21]

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.[22]

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.[23]

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

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare

[18] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[19] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[20] (Emphasis added.)
[21] 42 C.F.R. § 412.106(b)(2)-(3).
[22] (Emphasis added.)
[23] 42 C.F.R. § 412.106(b)(4).

inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[24] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[25]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[26] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[27] The Secretary then summarized his policy by stating that "our *current* policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[28]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[29] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[30] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted:

> The degree of difficulty depends on the data provided by the States, which may vary from one State to the next. Some States identify all dual-eligible beneficiaries in their lists of Medicaid patient days provided to the hospitals, while in other States the [Medicare contractor] must identify patient days attributable to dual-eligible beneficiaries by matching Medicare Part A bills with the list of Medicaid patients provided by the State. The latter case is problematic when Medicare Part A coverage is

[24] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.* at 27207-27208 (emphasis added).
[29] *Id.* at 27207-08.
[30] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.

> exhausted because no Medicare Part A bill may be submitted for these patients. Thus, the [Medicare contractor] has no data by which to readily verify any adjustment for these cases in the Medicaid data provided by the hospital. Currently, the [Medicare contractors] are reliant on the hospitals to identify the days attributable to dual-eligible beneficiaries so these days can be ***excluded*** *from the Medicaid patient days count*.[31]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[32] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[33] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [34] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[35]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[36] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[37]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[38] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual eligible beneficiaries in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days

[31] 68 Fed. Reg. at 27208 (emphasis added).
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[37] *Id.*
[38] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[39]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[40]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[41] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[42] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*

[39] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[40] *Id.* at 49099 (emphasis added).
[41] *Id.*
[42] *See id.* at 49099, 49246.

> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[43]

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

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[44]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[45]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[46] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our* ***revised*** *policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of

[43] (Emphasis added.)
[44] (Emphasis added.)
[45] *Id.*
[46] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).

> whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[47]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[48] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[49] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule was *not* procedurally defective.[50] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[51] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[52] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[53] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[54] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[55]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[56] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[57] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R.

---

[47] (Citations omitted and emphasis added.)
[48] 317 F. Supp. 3d 168 (D.D.C. 2018).
[49] *Id.* at 172.
[50] *Id.* at 190.
[51] *Id.* at 194.
[52] *See* 2019 WL 668282.
[53] 718 F.3d 914 (2013).
[54] 657 F.3d 1 (D.C. Cir. 2011).
[55] 718 F.3d at 920.
[56] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[57] *Id.* at 1141.

§ 412.106(b)(2) was substantively and procedurally invalid.[58] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[59] and that the regulation is procedurally invalid.[60]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[61] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[62] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[63] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[64] wherein the Ninth Circuit considered the meaning of the words "entitled" and "eligible" in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[65] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[66] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[67] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

[58] *Id.*
[59] *Id.* at 1162.
[60] *Id.* at 1163
[61] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[62] *Id.* at 884.
[63] *Id.* at 884.
[64] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[65] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[66] *Id.* at 886.
[67] *Id.*

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

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[68] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

IV. Providers' Position

The Providers in the CIRP group requested EJR to challenge the inclusion of certain Part A non-covered (*e.g.*, Part A exhausted) patient days in the Medicare fraction of the DSH calculation. The Providers argue that CMS has been inconsistent with the treatment of days for Medicare inpatients who have exhausted their Part A benefits or whose days have otherwise not been paid (Part A exhausted and other non-covered days). They note that, while historically these days were not counted in the Medicare fraction, CMS proposed in the FY 2004 IPPS Proposed Rule to count the days for patients who were dually-eligible in the numerator of the Medicaid fraction. However, CMS did not enact this proposal. Rather, in the FY 2005 IPPS Final Rule, CMS finalized the opposite policy: Part A exhausted and non-covered days would be counted in the Medicare fraction, and these days would be excluded from dual-eligible days in the Medicaid fraction numerator. The Providers assert that this policy change resulted in those exhausted non-covered days associated with dually eligible patients being excluded from the Medicaid fraction's numerator and only potentially being included in the Medicare fraction's numerator.[69]

The Providers contend that the policy adopted in the FY 2005 IPPS Final Rule and the associated regulatory changes were substantively and/or procedurally invalid. They claim that these no-pay Part A days should be included in the numerator of the Medicaid fraction (for the subset of those days associated with dually-eligible patients) and excluded in full from the Medicare fraction (both the numerator and denominator) because these days relate to patients who were not "entitled to" Part A benefits "for such days" when the services were provided. They state that CMS' policy deserves no deference. They contend that CMS misstated both its current and proposed policies in its FY 2004 and 2005 rulemaking, failed to provide adequate notice and opportunity for comment, and has interpreted "entitled to benefits under [Medicare Part A]" for purposes of the DSH fractions in a manner inconsistent with the statute and precedent. They note that the Ninth Circuit's decision in *Empire Health Foundation v. Azar* vacated the regulation at issue.[70] The Providers maintain EJR is appropriate because the regulation was held to be invalid and is being reviewed by the Supreme Court, and because the Board lacks the authority to review the validity of a regulation.[71]

---

[68] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).
[69] EJR Request at 4-5.
[70] *Id.* at 6 (citing to 958 F.3d 873 (9th Cir. 2020).
[71] *Id.* at 5-6.

V. Decision of the Board

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

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

All of the Providers in this CIRP group appeal have FYEs prior to December 31, 2016.

1. Statutory and Regulatory Background

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[72] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[73]

On August 21, 2008, new regulations governing the Board became effective.[74] Among these new regulations was 42 C.F.R. § 405.1835(a)(1)(ii) which added the requirement for cost report periods ending on or after December 31, 2008 that providers who were self-disallowing specific items to do so by following the procedures for filing a cost report under protest.

This new regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[75] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[76]

---

[72] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[73] *Bethesda*, 108 S. Ct. at 1258-59.
[74] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[75] 201 F. Supp. 3d 131 (D.D.C. 2016).
[76] *Id.* at 142.

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which addresses dissatisfaction with Medicare Contractor determinations for cost report periods which end on or after December 31, 2008 but 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) are no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

2. *Jurisdiction over Case Nos. 19-1555GC(A) and 19-1555GC(B) and the Underlying Participants*

On April 1, 2022, the Medicare contractor filed a response to the Providers' EJR Request. They noted that there are no jurisdictional impediments, but that the issue in these group appeals contain multiple components (challenging aspects of the SSI Ratio and Medicaid Fraction). Since group cases must contain one single issue, these cases do not comply with the Board's Rules and EJR is not appropriate until the cases have been bifurcated.

The Provider replied the Medicare Contractor's response on April 13, 2022 arguing that it is appropriate to keep the cases as one issue and states:

> Contrary to FSS' assertion, bifurcation is not warranted here, and EJR is appropriate at this time. In each of the above-referenced EJR requests, the Providers are seeking EJR on the Part A exhausted or non-covered days issue, that is, whether the Provider's DSH payment was improperly low because of the failure to properly account for inpatient days attributable to patients where there was no Medicare coverage or where Medicare did not make Part A payment, in both the Medicare SSI fraction and the Medicaid fraction. PRRB Rule 8 ("Framing Issues for Adjustments Involving Multiple Components") expressly recognizes this as single issue with multiple components, described as "Dual eligible Medicare Part A/Medicaid, which is often referred to as dual eligible Medicare Part A Exhausted and Noncovered Days." Accordingly, FSS' position that each of the appeals should be bifurcated because it contains multiple DSH components (i.e., the SSI ratio and Medicaid fraction) is contrary to the PRRB rules. FSS' assertion that the cases should be bifurcated "as has historically been the case" unnecessarily focuses on form over substance and ignores that the PRRB currently recognizes this as a single issue with multiple components.

As discussed in Section II and in Section V.B below, the Board agrees with the Medicare Contractor that there are two legal issues and has bifurcated this original case into Case Nos. 19-1555GC(A) and 19-1555GC(B) in compliance with 42 C.F.R. §§ 405.1837(b)(1) and 405.1837(f)(2)(ii).[77] Further, the Board has determined that the Exhausted Part A/Dual Eligible Days issues in the instant CIRP group case, are governed by CMS Ruling CMS-1727-R since they are challenging the FY 2005 IPPS Final Rule and that Board review of the issues is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[78] The appeals were timely filed and no jurisdictional impediments have been identified for the remaining participants. Finally, the Board notes that each Provider was directly added to this CIRP group appeal, and that the group issue statement includes a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions. Based on the foregoing, the Board finds that it has jurisdiction for Case Nos. 19-1555GC(A) and 19-1555GC(B).

B. Board's Analysis of the Appealed Issue

42 C.F.R. § 405.1867 specifies that "[i]n exercising its authority to conduct proceedings under this subpart, the Board ***must*** *comply with* all the provisions of Title XVIII of the Act and *regulations issued thereunder* . . . ."[79] Consequently the Board finds that it is bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Providers, namely: (1) invalidating the FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issue and calendar year under appeal in this case.

In making this finding, the Board notes that, as described above, the Providers maintain in their EJR request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated (either procedurally or substantively) and that, instead of reverting back to the prior policy of the Secretary under which such days were counted in neither fraction, those days should be counted in the numerator of the Medicaid fraction to the extent they involve patients who were also Medicaid eligible.

As evidenced, by the 9th Circuit's decision in *Empire*, the invalidation of the DSH no-pay Part A days policy (as finalized in the FY 2005 IPPS Final Rule) does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that the 9th Circuit's decision in *Empire* only reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i) under which no-pay Part A days were counted in neither the Medicare fraction nor the Medicaid fraction.

---

[77] 42 C.F.R. § 405.1837(f)(2)(ii) states: "When the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."
[78] *See* 42 C.F.R. § 405.1837.
[79] (Emphasis added.)

Moreover, it is clear that the situation in the instant case is not as simple as the one presented in *Allina Health Servs. v. Sebelius* ("*Allina*").[80] In *Allina*, the 9th Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in Allina stated: "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[81]

In contrast, this case involves no-pay Part A days and the subset of no-pay Part A days associated with dual eligibles. It is clear that the *class of patients* who are dually eligible do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, with respect to this *patient class*, any days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction and included in the Medicaid fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits).[82] To this end, the Providers are asserting that only in *certain* ***no-pay*** Part A situations that involve a dual eligible beneficiary (*e.g.*, exhausted benefits and MSP) must the days associated with this class of patients be excluded from the SSI fraction and included in the Medicaid fraction.

Similarly, the class of patients who have Medicare Part A includes dual eligibles and that, with respect to this larger patient class, any days associated with them may not be excluded *in toto* (*i.e.*, it is undisputed that some Part A patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits). Significantly, under the Providers' desired interpretation of the DSH statute, any days associated with no-Pay Part A days for which the beneficiary was *not* Medicaid eligible (*i.e.*, the patient was not a dual eligible) would not be counted in either the Medicare or Medicaid fraction.

Accordingly, the Board disagrees with the Providers' assertion that exclusion of days associated with no-pay Part A situations where the underlying patient is a dual eligible *automatically* means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to: (1) the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*");[83] and (2) CMS Ruling 1498-R2, wherein multiple possible treatments of no-pay dual eligible days are discussed and wherein CMS reconfirms that its policy prior to October 1, 2004 was to exclude all no-pay Part A days from the Medicare and Medicaid fractions even where the underlying patient was also eligible for Medicaid, stating:

> Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was

[80] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[81] *Id*. (emphasis added).
[82] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[83] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients

> entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 CFR 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098).[84]

Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[85] Thus, in the event the Supreme Court upholds the 9th Circuit's decision in *Empire*, the Providers would be arguing that the CMS' prior policy of excluding from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.[86]

Accordingly, the Board continues to maintain that the legal argument related to the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the legal argument related to the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the subset of no-pay part A days that involve patients who are also eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating this EJR request as a consolidated request involving the common issues underlying Case Nos. 19-1555GC(A) and 19-1555GC(B) as set forth in Section II.

C. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Providers in Case Nos. 19-1555GC(A) and 19-1555GC(B) are entitled to a hearing before the Board;

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

---

[84] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.
[85] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater*").
[86] *See also supra* note 9.

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 in Case No. 19-1555GC(A) of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid and the legal question in Case No. 19-1555GC(B) of what policy should then apply, namely whether to exclude or include such no-pay Part A days which involve a dual eligible from the Medicaid fraction if all no-pay Part A days are excluded from the Medicare fraction.

Accordingly, the Board concludes that the questions in Finding No. 4 properly fall 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. Further, the Board closes these group cases and removes them from the Board's docket.[87] The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

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

FOR THE BOARD:

5/4/2022

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Scott Berends, FSS

[87] In granting EJR and closing each of these group cases, the Board notes a group case can only have one legal issue pursuant to 42 C.F.R. §§ 405.1837(a)(2), (f)(2) and that, following full formation of the group, the Providers have not identified any other pending issue(s) outside of their EJR request.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nina Marsden, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Ste 1600
Los Angeles, CA 90067

RE: ***EJR Determination***
MemorialCare CY 2017 Medicare Part A Days CIRP Group
Case Nos. 20-1396GC(A), 20-1396GC(B)

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 28, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal involving MemorialCare. The decision of the Board is set forth below.

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

By letter dated April 25, 2022, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group case consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On March 22, 2022, subsequent to the submission of the EJR request in this appeal, the Board notified you of the relevance of Alert 19 to the EJR request. In particular, the Board notified you of the following:

> As the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under" the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b).

In this regard, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "***only if*** . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days ***after*** finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete."[1] Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[2]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. The issuance of this determination completes the Board jurisdictional review process and the Board is concurrently issuing its determination on the EJR request as the Board is familiar with the legal issues raised in the EJR request and has previously issued similar EJR determinations for those legal issues.

II. Issue in Dispute

The Dual Eligible days issue in this CIRP group appeal is framed as follows:

> DSH - SSI and Medicaid Fractions - Medicare Part A Days
>
> Whether the Provider's DSH payment for the period under appeal was improperly low because of the failure to properly account for inpatient days attributable to patients where there was no Medicare coverage or where Medicare did not make Part A payment, including, but not limited to, Part A exhausted days and Medicare Secondary Payer ("MSP") days. This issue relates both to the Medicare/SSI fraction and the Medicaid fraction.

[1] (Emphasis added.)
[2] (Emphasis added.)

> In accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), days relating to hospital inpatients who, at the time of service, were "eligible for medical assistance under a State plan approved under title XIX," but "not entitled to benefits under [Medicare] Part A" are to be included in the numerator of the Medicaid fraction. Dually-eligible Part A exhausted days, MSP days, and other similar days should be included in the numerator of the Medicaid fraction and excluded from the Medicare fraction because, by definition, those days relate to patients who were not "entitled to" Medicare Part A benefits when services were provided. Non-dually eligible Part A exhausted days, MSP days, and other similar days should be excluded from the Medicare fraction for the same reason.
>
> The Provider's DSH payment should be recalculated to ensure that (a) all dually-eligible Part A exhausted days, MSP days, and other similar days are included in the numerator of the Medicaid fraction and excluded from the Medicare/SSI fraction and (b) all non-dually-eligible Part A exhausted days, MSP days, and other similar days are excluded from the Medicare/SSI fraction. [3]

In the Providers' request for EJR, they frame the legal question as follows:

> The Group Appeal challenges the regulation and policy of [CMS], promulgated as part of the FY 2005 IPPS Final Rule, *to count exhausted or otherwise non-covered days for patients eligible for Medicare in the Medicare/SSI fraction* ***and*** *not, where the patient is dually eligible for Medicaid, in the Medicaid fraction*, as adopted and applied by CMS for purposes of calculating the Hospitals' Medicare [DSH] payments during their respective fiscal years included in the Group Appeal.[4]

The following excerpts shed additional light on the nature of this legal question:

- "As Section III below shows, the Hospitals are challenging the validity of CMS's regulation and policy to count exhausted or otherwise non-covered days for patients eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction."[5]

- "Part A exhausted or noncovered days should, for dually-eligible patients, be ***included*** *in the numerator of the Medicaid fraction,* ***and*** ***excluded*** *from the Medicare/SSI fraction*, because, by definition, those days relate to patients who were not 'entitled to' Medicare Part A benefits 'for such days' when the services were

[3] Group Issue Statement (Mar. 12, 2020).
[4] Request for Expedited Judicial Review, 1-2 (Mar. 28, 2022) ("EJR Request").
[5] *Id.* at 2 (emphasis added).

provided. Part A exhausted days and noncovered days should be excluded from the Medicare/SSI fraction for the same reason."[6]

- "Accordingly, CMS's regulation and policy requiring *including* Part A exhausted and other noncovered days in the Medicare/SSI fraction, ***and*** *excluding* such days from the numerator of the Medicaid fraction for dually-eligible patients, are 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,' 5 U.S.C. §706(2)(A), 'in excess of statutory jurisdiction, authority, or limitations, or short of statutory right,' id. §706(2)(C), and/or were not promulgated in accordance with applicable notice and comment requirements under, 42 U.S.C. §1395hh and/or 5 U.S.C. §553."[7]

The Board takes administrative notice that it has generally required the formation of two separate groups for the Exhausted Part A Days issue when the issue statement for the appeal requests not just exclusion of no-pay Part A days from the Medicare fraction (aka the SSI fraction) but also the inclusion, in the Medicaid fraction, of the subset of those days for which the underlying patient was also Medicaid eligible (*i.e.*, was a dual eligible) because, in that instance, there are two legal issues.[8] Specifically, in these instances, the Board has usually required bifurcation of the appeal to create two CIRP groups. First, one CIRP group for the "SSI Fraction/Dual Eligible Days" issue, which challenges the inclusion of noncovered Medicare days in the SSI fraction (as mandated by the regulatory revisions made by the FY 2005 IPPS Final Rule). Second, a CIRP group for the "Medicaid Fraction/Dual Eligible Days" issue, which alleges that, if the days at issue are excluded from the SSI fraction (*i.e.*, following a successful reversal of the regulatory revisions made by the FY 2005 IPPS Final Rule), then the subset of days that are associated with Medicaid eligible patients should be included in the numerator of the Medicaid fraction (as opposed to simply being excluded from the SSI fraction and the numerator of the Medicaid fraction as was done prior to the FY 2005 IPPS Final Rule).[9]

The Board notes that the group issue statement in this case contains a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions. The statute and regulations governing group appeals specifically note that a provider has a right to a Board hearing as part of a group appeal with other providers "***only if*** . . . [t]he matter at issue in the group appeal involves a ***single*** question of fact or interpretation of law,

---

[6] *Id.* at 5 (emphasis added).
[7] *Id.* at 6 (emphasis added.)
[8] The Board also takes administrative notice that, when processing EJR requests on these two issues, it is correcting any limited situations where the Board may have previously consolidated these two issues in error.
[9] The point of Rule 8 was to confirm that, at a minimum, Part A exhausted and noncovered days must be considered separately from other DSH components issues such as Medicare Part C days. Thus, the reference in Board Rule 8 to dual eligible Medicare Part A exhausted and noncovered days as a common example of a component issue in DSH does not mean that an appeal challenging that component could not itself have multiple issues. In this regard, the Board takes administrative notice that many appeals of this DSH issue simply seek to overturn the policy change made in the FY 2005 IPPS Final Rule to revert back to the prior policy, *i.e.*, excluding no-pay Part A days from both the SSI fraction and Medicaid fraction. The Board considers this example to be one issue which is different than what the Providers are seeking in this CIRP group. Again the Board must determine on a case-by-case basis because providers appealing a subject matter may make disparate legal arguments and/or seek disparate relief.

regulations, or CMS Rulings that is common to each provider in the group[.]"[10] Further, "[w]hen the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."[11]

As discussed below in Section V.B, since the Board has determined jurisdiction is proper for all participants for both issues, and for the sake of judicial economy, the Board is hereby bifurcating this CIRP Group Appeal into the following cases, as reflected in the attached Schedules of Providers:

- 20-1396GC(A): MemorialCare CY 2017 Medicare Part A Days CIRP Group/SSI Fraction
- 20-1396GC(B): MemorialCare CY 2017 Medicare Part A Days CIRP Group/Medicaid Fraction[12]

III. Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[13] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[14]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[15] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[16]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[17] 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

---

[10] 42 C.F.R. § 405.1837(a)(2). *See also* 42 U.S.C. 1395oo(b) (noting that a group appeal is proper "***only if*** the matters in controversy involve a common question of fact or interpretation of law or regulations . . .").
[11] 42 C.F.R. § 405.1837(f)(2)(ii).
[12] As these cases have the same record up to this point and there will be no further proceedings before the Board following this decision, the Board has opted for purposes of administrative efficiency not to create a separate case number within OH-CDMS at this time. Should additional proceedings before the Board occur in these cases on remand to the Board, then the Board would do so at that time, as appropriate and relevant.
[13] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[14] *Id.*
[15] *See* 42 U.S.C. § 1395ww(d)(5).
[16] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[17] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).

hospital.[18] The DPP is defined as the sum of two fractions expressed as percentages.[19] 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 . . . .[20]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[21]

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.[22]

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.[23]

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

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the

[18] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[19] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[20] (Emphasis added.)
[21] 42 C.F.R. § 412.106(b)(2)-(3).
[22] (Emphasis added.)
[23] 42 C.F.R. § 412.106(b)(4).

percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[24] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[25]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[26] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[27] The Secretary then summarized his policy by stating that "our *current* policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[28]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[29] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[30] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted:

> The degree of difficulty depends on the data provided by the States, which may vary from one State to the next. Some States identify all dual-eligible beneficiaries in their lists of Medicaid patient days provided to the hospitals, while in other States the [Medicare contractor] must identify patient days attributable to dual-eligible beneficiaries by matching Medicare Part A bills with the list of Medicaid patients provided by the State. The latter case is problematic when Medicare Part A coverage is exhausted because no Medicare Part A bill may be

[24] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.* at 27207-27208 (emphasis added).
[29] *Id.* at 27207-08.
[30] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.

> submitted for these patients. Thus, the [Medicare contractor] has no data by which to readily verify any adjustment for these cases in the Medicaid data provided by the hospital. Currently, the [Medicare contractors] are reliant on the hospitals to identify the days attributable to dual-eligible beneficiaries so these days can be ***excluded*** *from the Medicaid patient days count*.[31]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[32] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[33] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [34] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[35]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[36] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[37]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[38] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual eligible beneficiaries in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that

[31] 68 Fed. Reg. at 27208 (emphasis added).
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[37] *Id.*
[38] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[39]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[40]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[41] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[42] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and

[39] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[40] *Id.* at 49099 (emphasis added).
[41] *Id.*
[42] *See id.* at 49099, 49246.

> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[43]

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

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[44]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[45]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[46] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our* ***revised*** *policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were

[43] (Emphasis added.)
[44] (Emphasis added.)
[45] *Id.*
[46] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).

> exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[47]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[48] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[49] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule was *not* procedurally defective.[50] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[51] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[52] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[53] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[54] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[55]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[56] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[57] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[58] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before

[47] (Citations omitted and emphasis added.)
[48] 317 F. Supp. 3d 168 (D.D.C. 2018).
[49] *Id.* at 172.
[50] *Id.* at 190.
[51] *Id.* at 194.
[52] *See* 2019 WL 668282.
[53] 718 F.3d 914 (2013).
[54] 657 F.3d 1 (D.C. Cir. 2011).
[55] 718 F.3d at 920.
[56] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[57] *Id.* at 1141.
[58] *Id.*

the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[59] and that the regulation is procedurally invalid.[60]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[61] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[62] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[63] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[64] wherein the Ninth Circuit considered the meaning of the words "entitled" and "eligible" in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[65] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[66] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[67] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

---

[59] *Id.* at 1162.
[60] *Id.* at 1163
[61] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[62] *Id.* at 884.
[63] *Id.* at 884.
[64] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[65] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[66] *Id.* at 886.
[67] *Id.*

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[68] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

IV. Providers' Position

The Providers in the CIRP group requested EJR to challenge the inclusion of certain Part A non-covered (*e.g.*, Part A exhausted) patient days in the Medicare fraction of the DSH calculation. The Providers argue that CMS has been inconsistent with the treatment of days for Medicare inpatients who have exhausted their Part A benefits or whose days have otherwise not been paid (Part A exhausted and other non-covered days). They note that, while historically these days were not counted in the Medicare fraction, CMS proposed in the FY 2004 IPPS Proposed Rule to count the days for patients who were dually-eligible in the numerator of the Medicaid fraction. However, CMS did not enact this proposal. Rather, in the FY 2005 IPPS Final Rule, CMS finalized the opposite policy: Part A exhausted and non-covered days would be counted in the Medicare fraction, and these days would be excluded from dual-eligible days in the Medicaid fraction numerator. The Providers assert that this policy change resulted in those exhausted non-covered days associated with dually eligible patients being excluded from the Medicaid fraction's numerator and only potentially being included in the Medicare fraction's numerator.[69]

The Providers contend that the policy adopted in the FY 2005 IPPS Final Rule and the associated regulatory changes were substantively and/or procedurally invalid. They claim that these no-pay Part A days should be included in the numerator of the Medicaid fraction (for the subset of those days associated with dually-eligible patients) and excluded in full from the Medicare fraction (both the numerator and denominator) because these days relate to patients who were not "entitled to" Part A benefits "for such days" when the services were provided. They state that CMS' policy deserves no deference. They contend that CMS misstated both its current and proposed policies in its FY 2004 and 2005 rulemaking, failed to provide adequate notice and opportunity for comment, and has interpreted "entitled to benefits under [Medicare Part A]" for purposes of the DSH fractions in a manner inconsistent with the statute and precedent. They note that the Ninth Circuit's decision in *Empire Health Foundation v. Azar* vacated the regulation at issue.[70] The Providers maintain EJR is appropriate because the regulation was held to be invalid and is being reviewed by the Supreme Court, and because the Board lacks the authority to review the validity of a regulation.[71]

V. Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific

[68] *Bacerra v. Empire Health Fdtn*., No. 20-1312 (S. Ct. cert. granted July 2, 2021).
[69] EJR Request at 4-5.
[70] *Id.* at 6 (citing to 958 F.3d 873 (9th Cir. 2020).
[71] *Id.* at 5-6.

legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

A. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

All of the Providers in this group case have cost report periods beginning after January 1, 2016.

1. Jurisdiction over Case Nos. 20-1396GC(A) and 20-1396GC(B) and the Underlying Participants

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[72] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[73] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the MAC or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). As all of the participants in these 2 CIRP group appeals have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

On April 1, 2022, the Medicare contractor filed a response to the Providers' EJR Request. They noted that there are no jurisdictional impediments, but that the issue in these group appeals contain multiple components (challenging aspects of the SSI Ratio and Medicaid Fraction). Since group cases must contain one single issue, these cases do not comply with the Board's Rules and EJR is not appropriate until the cases have been bifurcated.

The Provider replied the Medicare Contractor's response on April 13, 2022 arguing that it is appropriate to keep the cases as one issue and states:

> Contrary to FSS' assertion, bifurcation is not warranted here, and EJR is appropriate at this time. In each of the above-referenced EJR requests, the Providers are seeking EJR on the Part A exhausted or

[72] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[73] *Id.* at 70555.

> non-covered days issue, that is, whether the Provider's DSH payment was improperly low because of the failure to properly account for inpatient days attributable to patients where there was no Medicare coverage or where Medicare did not make Part A payment, in both the Medicare SSI fraction and the Medicaid fraction. PRRB Rule 8 ("Framing Issues for Adjustments Involving Multiple Components") expressly recognizes this as single issue with multiple components, described as "Dual eligible Medicare Part A/Medicaid, which is often referred to as dual eligible Medicare Part A Exhausted and Noncovered Days." Accordingly, FSS' position that each of the appeals should be bifurcated because it contains multiple DSH components (i.e., the SSI ratio and Medicaid fraction) is contrary to the PRRB rules. FSS' assertion that the cases should be bifurcated "as has historically been the case" unnecessarily focuses on form over substance and ignores that the PRRB currently recognizes this as a single issue with multiple components.

As discussed in Section II and in Section V.B below, the Board agrees with the Medicare Contractor that there are two legal issues and has bifurcated this original case into Case Nos. 20-1396GC(A) and 20-1396GC(B) in compliance with 42 C.F.R. §§ 405.1837(b)(1) and 405.1837(f)(2)(ii).[74] Further, based on its review of the record, the Board finds that each of the participants in these 2 CIRP groups filed their appeals as a direct add within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, that and no jurisdictional impediments have been identified for the remaining participants, that the group issue statement includes a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). Based on the foregoing, the Board finds that it has jurisdiction for Case Nos. 20-1396GC(A) and 20-1396GC(B).

2. *Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016*

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, 413.24(j) requires that:

> (1) In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of

[74] 42 C.F.R. § 405.1837(f)(2)(ii) states: "When the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."

> this section), must include an appropriate claim for the specific item, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) Self-disallowance procedures. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). **If** the provider files an appeal to the Board seeking reimbursement for the specific item and **any party** to such appeal **questions whether the provider's cost report included an appropriate claim for the specific item**, the Board must address such question in accordance with the procedures set forth in this section.

These regulations are applicable to the cost reporting periods under appeal for four providers in these cases. The regulation at § 405.1873(b) sets out certain procedures that must be followed in

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[75] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[76] In this case, the Medicare Contractor has failed to file a Substantive Claim Challenge within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers in the group appeal.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[77] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

B. Board's Analysis of the Appealed Issue

42 C.F.R. § 405.1867 specifies that "[i]n exercising its authority to conduct proceedings under this subpart, the Board ***must*** *comply with* all the provisions of Title XVIII of the Act and *regulations issued thereunder* . . . ."[78] Consequently the Board finds that it is bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Providers, namely: (1) invalidating the FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issue and calendar year under appeal in this case.

In making this finding, the Board notes that, as described above, the Providers maintain in their EJR request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated (either procedurally or substantively) and that, instead of reverting back to the prior policy of the Secretary under which such days were counted in neither

---

[75] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[76] *See* 42 C.F.R. § 405.1873(a).
[77] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[78] (Emphasis added.)

fraction, those days should be counted in the numerator of the Medicaid fraction to the extent they involve patients who were also Medicaid eligible.

As evidenced, by the 9th Circuit's decision in *Empire*, the invalidation of the DSH no-pay Part A days policy (as finalized in the FY 2005 IPPS Final Rule) does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that the 9th Circuit's decision in *Empire* only reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i) under which no-pay Part A days were counted in neither the Medicare fraction nor the Medicaid fraction.

Moreover, it is clear that the situation in the instant case is not as simple as the one presented in *Allina Health Servs. v. Sebelius* ("*Allina*").[79] In *Allina*, the 9th Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in Allina stated: "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[80]

In contrast, this case involves no-pay Part A days and the subset of no-pay Part A days associated with dual eligibles. It is clear that the *class of patients* who are dually eligible do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, with respect to this *patient class*, any days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction and included in the Medicaid fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were "entitled" to Part A benefits).[81] To this end, the Providers are asserting that only in *certain* ***no-pay*** Part A situations that involve a dual eligible beneficiary (*e.g.*, exhausted benefits and MSP) must the days associated with this class of patients be excluded from the SSI fraction.

Similarly, the class of patients who have Medicare Part A includes dual eligibles and that, with respect to this larger patient class, any days associated with them may not be excluded *in toto* (*i.e.*, it is undisputed that some Part A patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits). Significantly, under the Providers' desired interpretation of the DSH statute, any days associated with no-Pay Part A days for which the beneficiary was *not* Medicaid eligible (*i.e.*, the patient was not a dual eligible) would not be counted in either the Medicare or Medicaid fraction.

Accordingly, the Board disagrees with the Providers' assertion that exclusion of days associated with these no-pay Part A situations where the underlying patient is a dual eligible *automatically* means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to: (1) the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic*

[79] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[80] *Id*. (emphasis added).
[81] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).

Health");[82] and (2) CMS Ruling 1498-R2, wherein multiple possible treatments of no-pay dual eligible days are discussed and wherein CMS reconfirms that its policy prior to October 1, 2004 was to exclude all no-pay Part A days from the Medicare and Medicaid fractions even where the underlying patient was also eligible for Medicaid, stating:

> Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 CFR 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098).[83]

Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[84] Thus, in the event the Supreme Court upholds the 9th Circuit's decision in *Empire*, the Providers would be arguing that the CMS' prior policy of excluding from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.[85]

Accordingly, the Board continues to maintain that the legal argument related to the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the legal argument related to the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the subset of no-pay part A days that involve patients who are also eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating this EJR request as a consolidated request involving the common issues underlying Case Nos. 20-1396GC(A) and 20-1396GC(B) as set forth in Section II.

---

[82] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients
[83] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.
[84] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater*").
[85] *See also supra* note 9.

C. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Providers in Case Nos. 20-1396GC(A) and 20-1396GC(B) are entitled to a hearing before the Board;

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

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

4) It is without the authority to decide the legal question in Case No. 20-1396GC(A) of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid and the legal question in Case No. 20-1396GC(B) of what policy should then apply, namely whether to exclude or include such no-pay Part A days which involve a dual eligible from the Medicaid fraction if all no-pay Part A days are excluded from the Medicare fraction.

Accordingly, the Board concludes that the questions in Finding No. 4 above properly fall 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. Further, the Board closes these group cases and removes them from the Board's docket.[86] The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

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

For the Board:

5/4/2022

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Scott Berends, FSS

[86] In granting EJR and closing each of these group cases, the Board notes a group case can only have one legal issue pursuant to 42 C.F.R. §§ 405.1837(a)(2), (f)(2) and that, following full formation of the group, the Providers have not identified any other pending issue(s) outside of their EJR request.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nina Marsden, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Ste 1600
Los Angeles, CA 90067

RE: ***EJR Determination***
MemorialCare CY 2018 Medicare Part A Days CIRP Group
Case Nos. 21-1222GC(A), 21-1222GC(B)

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 28, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal involving MemorialCare. The decision of the Board is set forth below.

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

By letter dated April 25, 2022, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group case consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On March 22, 2022, subsequent to the submission of the EJR request in this appeal, the Board notified you of the relevance of Alert 19 to the EJR request. In particular, the Board notified you of the following:

> As the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under" the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b).

In this regard, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "***only if*** . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days ***after*** finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete."[1] Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[2]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. The issuance of this determination completes the Board jurisdictional review process and the Board is concurrently issuing its determination on the EJR request as the Board is familiar with the legal issues raised in the EJR request and has previously issued similar EJR determinations for those legal issues.

II. Issue in Dispute

The Dual Eligible days issue in this CIRP group appeal is framed by the Providers, as follows:

> DSH - SSI and Medicaid Fractions - Medicare Part A Days
>
> Whether the Provider's DSH payment for the period under appeal was improperly low because of the failure to properly account for inpatient days attributable to patients where there was no Medicare coverage or where Medicare did not make Part A payment, including, but not limited to, Part A exhausted days and Medicare Secondary Payer ("MSP") days. This issue relates both to the Medicare/SSI fraction and the Medicaid fraction.
>
> In accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), days relating to hospital inpatients who, at the time of service, were "eligible for medical

[1] (Emphasis added.)
[2] (Emphasis added.)

> assistance under a State plan approved under title XIX," but "not entitled to benefits under [Medicare] Part A" are to be included in the numerator of the Medicaid fraction. Dually-eligible Part A exhausted days, MSP days, and other similar days should be included in the numerator of the Medicaid fraction and excluded from the Medicare fraction because, by definition, those days relate to patients who were not "entitled to" Medicare Part A benefits when services were provided. Non-dually eligible Part A exhausted days, MSP days, and other similar days should be excluded from the Medicare fraction for the same reason.
>
> The Provider's DSH payment should be recalculated to ensure that (a) all dually-eligible Part A exhausted days, MSP days, and other similar days are included in the numerator of the Medicaid fraction and excluded from the Medicare/SSI fraction and (b) all non-dually-eligible Part A exhausted days, MSP days, and other similar days are excluded from the Medicare/SSI fraction. [3]

In the Providers' request for EJR, they frame the legal question as follows:

> The Group Appeal challenges the regulation and policy of [CMS], promulgated as part of the FY 2005 IPPS Final Rule, to count exhausted or otherwise non-covered days for patients eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction, as adopted and applied by CMS for purposes of calculating the Hospitals' Medicare [DSH] payments during their respective fiscal years included in the Group Appeal.[4]

The following excerpts shed additional light on the nature of this legal question:

- "As Section III below shows, the Hospitals are challenging the validity of CMS's regulation and policy to count exhausted or otherwise non-covered days for patients eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction."[5]

- "Part A exhausted or noncovered days should, for dually-eligible patients, be ***included*** *in the numerator of the Medicaid fraction,* ***and excluded*** *from the Medicare/SSI fraction*, because, by definition, those days relate to patients who were not 'entitled to' Medicare Part A benefits 'for such days' when the services were provided. Part A exhausted days and noncovered days should be excluded from the Medicare/SSI fraction for the same reason."[6]

---

[3] Group Issue Statement (Apr. 20, 2021).
[4] Request for Expedited Judicial Review, 1-2 (Mar. 28, 2022) ("EJR Request").
[5] *Id.* at 2 (emphasis added).
[6] *Id.* at 5 (emphasis added).

- "Accordingly, CMS's regulation and policy requiring *including* Part A exhausted and other noncovered days in the Medicare/SSI fraction, ***and*** *excluding* such days from the numerator of the Medicaid fraction for dually-eligible patients, are 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,' 5 U.S.C. §706(2)(A), 'in excess of statutory jurisdiction, authority, or limitations, or short of statutory right,' id. §706(2)(C), and/or were not promulgated in accordance with applicable notice and comment requirements under, 42 U.S.C. §1395hh and/or 5 U.S.C. §553."[7]

The Board takes administrative notice that it has generally required the formation of two separate groups for the Exhausted Part A Days issue when the issue statement for the appeal requests not just exclusion of no-pay Part A days from the Medicare fraction (aka the SSI fraction) but also the inclusion, in the Medicaid fraction, of the subset of those days for which the underlying patient was also Medicaid eligible (*i.e.*, was a dual eligible) because, in that instance, there are two legal issues.[8] Specifically, in these instances, the Board has usually required bifurcation of the appeal to create two CIRP groups. First, one CIRP group for the "SSI Fraction/Dual Eligible Days" issue, which challenges the inclusion of noncovered Medicare days in the SSI fraction (as mandated by the regulatory revisions made by the FY 2005 IPPS Final Rule). Second, a CIRP group for the "Medicaid Fraction/Dual Eligible Days" issue, which alleges that, if the days at issue are excluded from the SSI fraction (*i.e.*, following a successful reversal of the regulatory revisions made by the FY 2005 IPPS Final Rule), then the subset of days that are associated with Medicaid eligible patients should be included in the numerator of the Medicaid fraction (as opposed to simply being excluded from the SSI fraction and the numerator of the Medicaid fraction as was done prior to the FY 2005 IPPS Final Rule).[9]

The Board notes that the group issue statement in this case contains a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions. The statute and regulations governing group appeals specifically note that a provider has a right to a Board hearing as part of a group appeal with other providers "***only if*** . . . [t]he matter at issue in the group appeal involves a ***single*** question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group[.]"[10] Further, "[w]hen

[7] *Id.* at 6 (emphasis added.)
[8] The Board also takes administrative notice that, when processing EJR requests on these two issues, it is correcting any limited situations where the Board may have previously consolidated these two issues in error.
[9] The point of Rule 8 was to confirm that, at a minimum, Part A exhausted and noncovered days must be considered separately from other DSH components issues such as Medicare Part C days. Thus, the reference in Board Rule 8 to dual eligible Medicare Part A exhausted and noncovered days as a common example of a component issue in DSH does not mean that an appeal challenging that component could not itself have multiple issues. In this regard, the Board takes administrative notice that many appeals of this DSH issue simply seek to overturn the policy change made in the FY 2005 IPPS Final Rule to revert back to the prior policy, *i.e.*, excluding no-pay Part A days from both the SSI fraction and Medicaid fraction. The Board considers this example to be one issue which is different than what the Providers are seeking in this CIRP group. Again the Board must determine on a case-by-case basis because providers appealing a subject matter may make disparate legal arguments and/or seek disparate relief.
[10] 42 C.F.R. § 405.1837(a)(2). *See also* 42 U.S.C. 1395oo(b) (noting that a group appeal is proper "***only if*** the matters in controversy involve a common question of fact or interpretation of law or regulations . . .").

the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."[11]

As discussed below in Section V.B, since the Board has determined jurisdiction is proper for all participants for both issues, and for the sake of judicial economy, the Board is hereby bifurcating this CIRP Group Appeal into the following cases, as reflected in the attached Schedules of Providers:

- 21-1222GC(A): MemorialCare CY 2018 Medicare Part A Days CIRP Group/SSI Fraction
- 21-1222GC(B): MemorialCare CY 2018 Medicare Part A Days CIRP Group/Medicaid Fraction[12]

III. Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[13] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[14]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[15] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[16]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[17] 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.[18] The DPP is defined as the sum of two fractions expressed as percentages.[19] Those

[11] 42 C.F.R. § 405.1837(f)(2)(ii).
[12] As these cases have the same record up to this point and there will be no further proceedings before the Board following this decision, the Board has opted for purposes of administrative efficiency not to create a separate case number within OH-CDMS at this time. Should additional proceedings before the Board occur in these cases on remand to the Board, then the Board would do so at that time, as appropriate and relevant.
[13] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[14] *Id*.
[15] *See* 42 U.S.C. § 1395ww(d)(5).
[16] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[17] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[18] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[19] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

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 . . . .[20]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[21]

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.[22]

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.[23]

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

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[24] The Secretary explained that, if a patient is a Medicare beneficiary

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

who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[25]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[26] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[27] The Secretary then summarized his policy by stating that "our *current* policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[28]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[29] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[30] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted:

> The degree of difficulty depends on the data provided by the States, which may vary from one State to the next. Some States identify all dual-eligible beneficiaries in their lists of Medicaid patient days provided to the hospitals, while in other States the [Medicare contractor] must identify patient days attributable to dual-eligible beneficiaries by matching Medicare Part A bills with the list of Medicaid patients provided by the State. The latter case is problematic when Medicare Part A coverage is exhausted because no Medicare Part A bill may be submitted for these patients. Thus, the [Medicare contractor] has no data by which to readily verify any adjustment for these cases in the Medicaid data provided by

[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.* at 27207-27208 (emphasis added).
[29] *Id.* at 27207-08.
[30] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.

> the hospital. Currently, the [Medicare contractors] are reliant on the hospitals to identify the days attributable to dual-eligible beneficiaries so these days can be ***excluded*** *from the Medicaid patient days count*.[31]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[32] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[33] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [34] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[35]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[36] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[37]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[38] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual eligible beneficiaries in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a

[31] 68 Fed. Reg. at 27208 (emphasis added).
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[37] *Id.*
[38] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[39]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[40]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[41] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[42] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and

[39] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[40] *Id.* at 49099 (emphasis added).
[41] *Id.*
[42] *See id.* at 49099, 49246.

> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[43]

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

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[44]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[45]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[46] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our* ***revised*** *policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an

[43] (Emphasis added.)
[44] (Emphasis added.)
[45] *Id.*
[46] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).

> individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[47]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[48] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[49] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule was *not* procedurally defective.[50] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[51] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[52] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[53] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[54] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[55]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[56] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[57] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[58] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington

---

[47] (Citations omitted and emphasis added.)
[48] 317 F. Supp. 3d 168 (D.D.C. 2018).
[49] *Id.* at 172.
[50] *Id.* at 190.
[51] *Id.* at 194.
[52] *See* 2019 WL 668282.
[53] 718 F.3d 914 (2013).
[54] 657 F.3d 1 (D.C. Cir. 2011).
[55] 718 F.3d at 920.
[56] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[57] *Id.* at 1141.
[58] *Id.*

District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[59] and that the regulation is procedurally invalid.[60]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[61] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[62] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[63] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[64] wherein the Ninth Circuit considered the meaning of the words "entitled" and "eligible" in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[65] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[66] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[67] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[68] Thus, as of the date of this decision, the Secretary's position with respect

[59] *Id.* at 1162.
[60] *Id.* at 1163
[61] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[62] *Id.* at 884.
[63] *Id.* at 884.
[64] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[65] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[66] *Id.* at 886.
[67] *Id.*
[68] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

IV. Providers' Position

The Providers in the CIRP group requested EJR to challenge the inclusion of certain Part A non-covered (*e.g.*, Part A exhausted) patient days in the Medicare fraction of the DSH calculation. The Providers argue that CMS has been inconsistent with the treatment of days for Medicare inpatients who have exhausted their Part A benefits or whose days have otherwise not been paid (Part A exhausted and other non-covered days). They note that, while historically these days were not counted in the Medicare fraction, CMS proposed in the FY 2004 IPPS Proposed Rule to count the days for patients who were dually-eligible in the numerator of the Medicaid fraction. However, CMS did not enact this proposal. Rather, in the FY 2005 IPPS Final Rule, CMS finalized the opposite policy: Part A exhausted and non-covered days would be counted in the Medicare fraction, and these days would be excluded from dual-eligible days in the Medicaid fraction numerator. The Providers assert that this policy change resulted in those exhausted non-covered days associated with dually eligible patients being excluded from the Medicaid fraction's numerator and only potentially being included in the Medicare fraction's numerator.[69]

The Providers contend that the policy adopted in the FY 2005 IPPS Final Rule and the associated regulatory changes were substantively and/or procedurally invalid. They claim that these no-pay Part A days should be included in the numerator of the Medicaid fraction (for the subset of those days associated with dually-eligible patients) and excluded in full from the Medicare fraction (both the numerator and denominator) because these days relate to patients who were not "entitled to" Part A benefits "for such days" when the services were provided. They state that CMS' policy deserves no deference. They contend that CMS misstated both its current and proposed policies in its FY 2004 and 2005 rulemaking, failed to provide adequate notice and opportunity for comment, and has interpreted "entitled to benefits under [Medicare Part A]" for purposes of the DSH fractions in a manner inconsistent with the statute and precedent. They note that the Ninth Circuit's decision in *Empire Health Foundation v. Azar* vacated the regulation at issue.[70] The Providers maintain EJR is appropriate because the regulation was held to be invalid and is being reviewed by the Supreme Court, and because the Board lacks the authority to review the validity of a regulation.[71]

V. Decision of the Board

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

[69] EJR Request at 4-5.
[70] *Id.* at 6 (citing to 958 F.3d 873 (9th Cir. 2020).
[71] *Id.* at 5-6.

A. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

All of the Providers in this group case have cost report periods beginning after January 1, 2016.

1. Jurisdiction over Case Nos. 21-1222GC(A) and 21-1222GC(B) and the Underlying Participants

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[72] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[73] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the MAC or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). As all of the participants in these 2 CIRP group appeals have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

On April 1, 2022, the Medicare contractor filed a response to the Providers' EJR Request. They noted that there are no jurisdictional impediments, but that the issue in these group appeals contain multiple components (challenging aspects of the SSI Ratio and Medicaid Fraction). Since group cases must contain one single issue, these cases do not comply with the Board's Rules and EJR is not appropriate until the cases have been bifurcated.

The Provider replied the Medicare Contractor's response on April 13, 2022 arguing that it is appropriate to keep the cases as one issue and states:

> Contrary to FSS' assertion, bifurcation is not warranted here, and EJR is appropriate at this time. In each of the above-referenced EJR requests, the Providers are seeking EJR on the Part A exhausted or non-covered days issue, that is, whether the Provider's DSH payment was improperly low because of the failure to properly account for inpatient days attributable to

[72] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[73] *Id.* at 70555.

> patients where there was no Medicare coverage or where Medicare did not make Part A payment, in both the Medicare SSI fraction and the Medicaid fraction. PRRB Rule 8 ("Framing Issues for Adjustments Involving Multiple Components") expressly recognizes this as single issue with multiple components, described as "Dual eligible Medicare Part A/Medicaid, which is often referred to as dual eligible Medicare Part A Exhausted and Noncovered Days." Accordingly, FSS' position that each of the appeals should be bifurcated because it contains multiple DSH components (i.e., the SSI ratio and Medicaid fraction) is contrary to the PRRB rules. FSS' assertion that the cases should be bifurcated "as has historically been the case" unnecessarily focuses on form over substance and ignores that the PRRB currently recognizes this as a single issue with multiple components.

As discussed in Section II and in Section V.B below, the Board agrees with the Medicare Contractor that there are two legal issues and has bifurcated this original case into Case Nos. 20-1396GC(A) and 20-1396GC(B) in compliance with 42 C.F.R. §§ 405.1837(b)(1) and 405.1837(f)(2)(ii).[74] Further, based on its review of the record, the Board finds that each of the participants in these 2 CIRP groups filed their appeals as a direct add within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, that and no jurisdictional impediments have been identified for the remaining participants, that the group issue statement includes a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3). Based on the foregoing, the Board finds that it has jurisdiction for Case Nos. 21-1222GC(A) and 21-1222GC(B).

2. *Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016*

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, 413.24(j) requires that:

> (1) In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—

[74] 42 C.F.R. § 405.1837(f)(2)(ii) states: "When the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."

> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) Self-disallowance procedures. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). **If** the provider files an appeal to the Board seeking reimbursement for the specific item and **any party** to such appeal **questions whether the provider's cost report included an appropriate claim for the specific item**, the Board must address such question in accordance with the procedures set forth in this section.

These regulations are applicable to the cost reporting periods under appeal for four providers in these cases. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires

the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[75] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[76] In this case, the Medicare Contractor has failed to file a Substantive Claim Challenge within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers in the group appeal.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[77] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

B. Board's Analysis of the Appealed Issue

42 C.F.R. § 405.1867 specifies that "[i]n exercising its authority to conduct proceedings under this subpart, the Board ***must*** *comply with* all the provisions of Title XVIII of the Act and *regulations issued thereunder . . . .*"[78] Consequently the Board finds that it is bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Providers, namely: (1) invalidating the FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issue and calendar year under appeal in this case.

In making this finding, the Board notes that, as described above, the Providers maintain in their EJR request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated (either procedurally or substantively) and that, instead of reverting back to the prior policy of the Secretary under which such days were counted in neither fraction, those days should be counted in the numerator of the Medicaid fraction to the extent they involve patients who were also Medicaid eligible.

---

[75] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[76] *See* 42 C.F.R. § 405.1873(a).
[77] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[78] (Emphasis added.)

As evidenced, by the 9th Circuit's decision in *Empire*, the invalidation of the DSH no-pay Part A days policy (as finalized in the FY 2005 IPPS Final Rule) does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that the 9th Circuit's decision in *Empire* only reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i) under which no-pay Part A days were counted in neither the Medicare fraction nor the Medicaid fraction.

Moreover, it is clear that the situation in the instant case is not as simple as the one presented in *Allina Health Servs. v. Sebelius* ("*Allina*").[79] In *Allina*, the 9th Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in Allina stated: "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[80]

In contrast, this case involves no-pay Part A days and the subset of no-pay Part A days associated with dual eligibles. It is clear that the *class of patients* who are dually eligible do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, with respect to this *patient class*, any days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction and included in the Medicaid fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were "entitled" to Part A benefits).[81] To this end, the Providers are asserting that only in *certain* ***no-pay*** Part A situations that involve a dual eligible beneficiary (*e.g.*, exhausted benefits and MSP) must the days associated with this class of patients be excluded from the SSI fraction.

Similarly, the class of patients who have Medicare Part A includes dual eligibles and that, with respect to this larger patient class, any days associated with them may not be excluded *in toto* (*i.e.*, it is undisputed that some Part A patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits). Significantly, under the Providers' desired interpretation of the DSH statute, any days associated with no-Pay Part A days for which the beneficiary was *not* Medicaid eligible (*i.e.*, the patient was not a dual eligible) would not be counted in either the Medicare or Medicaid fraction.

Accordingly, the Board disagrees with the Providers' assertion that exclusion of days associated with these no-pay Part A situations where the underlying patient is a dual eligible *automatically* means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to: (1) the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*");[82] and (2) CMS Ruling 1498-R2, wherein multiple possible treatments of no-pay dual eligible days are discussed and wherein CMS reconfirms that its policy prior to October 1, 2004

[79] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[80] *Id*. (emphasis added).
[81] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[82] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients

was to exclude all no-pay Part A days from the Medicare and Medicaid fractions even where the underlying patient was also eligible for Medicaid, stating:

> Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 CFR 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098).[83]

Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[84] Thus, in the event the Supreme Court upholds the 9th Circuit's decision in *Empire*, the Providers would be arguing that the CMS' prior policy of excluding from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.[85]

Accordingly, the Board continues to maintain that the legal argument related to the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the legal argument related to the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the subset of no-pay part A days that involve patients who are also eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating this EJR request as a consolidated request involving the common issues underlying Case Nos. 21-1222GC(A) and 21-1222GC(B) as set forth in Section II.

---

[83] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.
[84] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater*").
[85] *See also supra* note 9.

C. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Providers in Case Nos. 21-1222GC(A) and 21-1222GC(B) are entitled to a hearing before the Board;

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

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

4) t is without the authority to decide the legal question in Case No. 21-1222GC(A) of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid and the legal question in Case No. 21-1222GC(B) of what policy should then apply, namely whether to exclude or include such no-pay Part A days which involve a dual eligible from the Medicaid fraction if all no-pay Part A days are excluded from the Medicare fraction.

Accordingly, the Board finds that the questions in Finding No. 4 properly fall 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. Further, the Board closes these group cases and removes them from the Board's docket.[86] The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

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

For the Board:

5/4/2022

X Clayton J. Nix

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

Schedules of Providers

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Scott Berends, FSS

[86] In granting EJR and closing each of these group cases, the Board notes a group case can only have one legal issue pursuant to 42 C.F.R. §§ 405.1837(a)(2), (f)(2) and that, following full formation of the group, the Providers have not identified any other pending issue(s) outside of their EJR request.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Wilkes Regional Medical Center (Prov. No. 34-0064)
FYE 9/30/2009
Case No. 14-2674

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the documents filed in the above-captioned case. The Medicare Contractor has filed a Motion to Dismiss the Medicaid Eligible Days and the Medicaid Eligible Observation Days issues, and the decision of the Board is set forth below.

Background

Wilkes Regional Medical Center submitted a request for hearing on February 26, 2014 from a Notice of Program Reimbursement ("NPR") dated August 30, 2013. The hearing request included the following issues:

- Issue 1: DSH Medicaid Eligible Days
- Issue 2: DSH Medicaid Fraction Managed Care Part C Days
- Issue 3: DSH Medicaid Eligible Labor Room Days
- Issue 4: DSH Medicaid Fraction Dual Eligible Days
- Issue 5: DSH Medicaid Eligible Observation Bed Days
- Issue 6: Outlier Payments – Fixed Loss Threshold

On October 8, 2014, the Provider transferred Issues 2, 4, and 6 to group appeals. The Provider withdrew Issue 3 on October 31, 2014. The sole remaining issues are Issue 1 – DSH Medicaid Eligible Days and Issue 5 – DSH Medicaid Eligible Observation Bed Days.

On February 10, 2022, the Provider filed its final position paper ("FPP") briefing Issues 1 and 5. For Issue 1, the Provider essentially contends that additional Medicaid eligible days are required to be added to the Medicaid fraction but did not identify the alleged days in dispute (either by identifying how many or including a listing). Rather, the Provider stated that a listing would be sent under separate cover. Similarly, for Issue 5, the Provider essentially contends that

observation bed days were understated but failed to identify the alleged days in dispute (either identifying how many or including a listing). Unlike for Issue 1, the Provider did not state that a listing would be sent under separate cover.

On March 25, 2022, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days and Medicaid Eligible Observation Bed Days issues (Issue 1 and 5) arguing that the Provider has effectively abandoned the issues by failing to furnish in its FPP any documentation in support of its claim for additional Medicaid Eligible Days or Medicaid Eligible Observation Bed Days or describe in its FPP why such documentation was and continues to be unavailable. Similarly, the Provider failed to respond to the Medicare Contractor's February 21, 2022 request for a listing of the additional Medicaid eligible days referenced in the Provider's FPP as being forthcoming. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. The Medicare Contractor claims that no listing has ever been provided in the 97 months since the appeal was filed.

The Provider has not, to date, filed a response to the Medicare Contractor's Motion to Dismiss. Board Rule 44.3 gave the Provider 30 days to respond to the Motion:

> Unless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and the opposing party.

Controlling Regulations and Board Rules

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Mar. 2013) states:

> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Similarly, with regard to position papers,[1] Board Rule 25.2.1 requires that "the parties must exchange ***all*** available documentation as exhibits to fully support your position." [2]

[1] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* PRRB Rule 27.2.
[2] (Emphasis added).

Board Rule 25.2.2 provides the following instruction on the content of position papers:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[3]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

> - if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
> - upon failure of the provider or group to comply with Board procedures,

[3] (Emphasis added).

- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

Decision of the Board

The Board concurs with the Medicare Contractor that the Provider is required to provide documentation to prove the additional Medicaid Eligible days to which it may be entitled as it relates to Issues 1 and 5. Pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed" [4] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, and noting that the Provider has been provided sufficient opportunity to rebut the Medicare Contractor's claims,[5] the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided *any* explanation in its FPP (or any other filing) as to why the documentation was absent or what is being done to obtain it, notwithstanding its obligation to do so under Board Rules.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider's FPP failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims for Issues 1 and 5 or describe why said evidence is unavailable for Issues 1 and 5.[6] In this regard, the Board notes that, for Issue 1, the Provider represented in its final position paper filed on February 10, 2022 that "the Listing of Medicaid Eligible days [was] being sent under separate cover."[7] However, it did not explain why that listing was not then available as required by Board Rule 25.2.2 and no such listing has ever been received by either the Board or the Medicare Contractor (notwithstanding the Provider's representation that such a listing was available and ready and its now-ironic "request[] that the MAC review the Medicaid eligible days listing being sent under separate cover and provide a sample listing as soon as practicable"). Indeed, the Medicare Contractor represents that it followed up by email on February 21, 2022 requesting the listing of Medicaid eligible days that was promised but received no response. The Board notes that this appeal has been pending for over eight (8) years and that the Provider failed to respond to the Medicare Contractor's Motion to Dismiss Issue 1 and 5 within the 30 days allotted under Board Rule 44.3.

As such, the Board hereby dismisses Issue 1 – the DSH Medicaid Eligible Days issue and Issue 5 – the DSH Medicaid Eligible Observation Bed Days issue from the appeal. As these were the last remaining issues in the appeal, the Board hereby closes Case No. 14-2674 and removes it

[4] (Emphasis added).
[5] *See* Board Rule 44.3.
[6] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[7] Final Position Paper at 11.

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

Board Members Participating:

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

For the Board:

5/5/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Wilkes Regional Medical Center (Prov. No. 34-0064)
FYE 9/30/2012
Case No. 16-0054

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the documents filed in the above-captioned case. The Medicare Contractor has filed a Motion to Dismiss the Medicaid Eligible Days issue, and the decision of the Board is set forth below.

Background

Wilkes Regional Medical Center submitted a request for hearing on October 6, 2015 from a Notice of Program Reimbursement ("NPR") dated April 8, 2015. The hearing request included the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage (Systemic Errors)
- Issue 3: DSH SSI Fraction Managed Care Part C Days
- Issue 4: DSH SSI Fraction Dual Eligible Days
- Issue 5: DSH Medicaid Eligible Days
- Issue 6: DSH Medicaid Fraction Managed Care Part C Days
- Issue 7: DSH Medicaid Fraction Dual Eligible Days
- Issue 8: Outlier Payments – Fixed Loss Threshold

On June 22, 2016, the Provider transferred issues 2, 3, 4, 6, 7, and 8 to group appeals. Issue 1 was dismissed by the Board on April 28, 2022. The only remaining issue is Issue 5 – DSH Medicaid Eligible Days.

On February 10, 2022, the Provider filed its final position paper ("FPP"). The Provider's FPP essentially contends in its briefing of Issue 5 that additional Medicaid eligible days are required to be added to the Medicaid fraction; however, the FPP did not identify the alleged days in dispute (either by identifying how many or including a listing). Rather, the FPP states that a listing would be sent under separate cover.

On March 25, 2022, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish in its FPP any documentation in support of its claim for additional Medicaid Eligible Days or describe in its FPP why such documentation was and continues to be unavailable. Similarly, the Provider failed to respond to the Medicare Contractor's February 21, 2022 request for a listing of the additional Medicaid eligible days referenced in the Provider's FPP as being forthcoming. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. The Medicare Contractor claims that no listing has ever been provided in the 77 months since the appeal was filed.

The Provider has not, to date, filed a response to the Medicare Contractor's Motion to Dismiss. Board Rule 44.3 gave the Provider 30 days to respond to the Motion:

> Unless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and the opposing party.

Controlling Regulations and Board Rules

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Jul. 2015) states:

> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Similarly, with regard to position papers,[1] Board Rule 25.2.1 requires that "the parties must exchange ***all*** available documentation as exhibits to fully support your position." [2]

Board Rule 25.2.2 provides the following instruction on the content of position papers:

[1] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* PRRB Rule 27.2.
[2] (Emphasis added).

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[3]

The Board Rules addressing position papers are based on 42 C.F.R. § 405.1853(b) which states:

> (b) *Position papers*. (1) After any preliminary narrowing of the issues, the parties must **file position papers in order to narrow the issues further**. In each case, and as appropriate, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board.
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue**.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or **through general instructions**.[4]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

---

[3] (Emphasis added).
[4] (Bold and underline emphasis added.)

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures,
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

Decision of the Board

The Board concurs with the Medicare Contractor that the Provider is required to provide documentation to prove the additional Medicaid Eligible days to which it may be entitled under Issue 5. Pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed" [5] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, and noting that the Provider has been provided sufficient opportunity to rebut the Medicare Contractor's claims,[6] the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation in it FPP (or any other filing) as to why the documentation was absent or what is being done to obtain it, notwithstanding its obligation to do so under Board Rules.

[5] (Emphasis added).
[6] *See* Board Rule 44.3.

As noted in the commentary to Board Rule 23.3, position papers are "to be fully developed and include all available documentation necessary to provide a thorough understanding of the parties' positions" and here the Provider has failed to do so for the sole remaining issue. In this regard, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[7] In this regard, the Board notes that the Provider represented in its final position paper filed on February 10, 2022 that "the Listing of Medicaid Eligible days [was] being sent under separate cover."[8] However, no such listing has ever been received by either the Board or the Medicare Contractor (notwithstanding the Provider's representation that such a listing was available and ready and its now-ironic "request[] that the MAC review the Medicaid eligible days listing being sent under separate cover and provide a sample listing as soon as practicable"). The Board notes that this appeal has been pending for nearly eight (8) years and that the Provider failed to respond to the Medicare Contractor's Motion to Dismiss within the 30 days allotted under Board Rule 44.3.

As such, the Board hereby dismisses Issue 5, the DSH Medicaid Eligible Days issue, from the appeal pursuant to its authority under 42 C.F.R. § 405.1868(b). As this was the last remaining issue in the appeal, the Board hereby closes Case No. 16-0054 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

5/5/2022

X Clayton J. Nix

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

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

[7] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[8] Final Position Paper at 11.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Wilkes Regional Medical Center (Prov. No. 34-0064)
FYE 9/30/2013
Case No. 16-2521

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the documents filed in the above-captioned case. The Medicare Contractor has filed a Motion to Dismiss the Medicaid Eligible Days issue, and the decision of the Board is set forth below.

Background

Wilkes Regional Medical Center submitted a request for hearing on September 23, 2016 from a Notice of Program Reimbursement ("NPR") dated March 29, 2016. The hearing request included the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage (Systemic Errors)
- Issue 3: DSH Medicare Part C Days – SSI Fraction
- Issue 4: DSH Dual Eligible Days Exhausted Part A – SSI Fraction
- Issue 5: DSH Medicaid Eligible Days
- Issue 6: DSH Medicare Part C Days – Medicaid Fraction
- Issue 7: DSH Dual Eligible Days Exhausted Part A – Medicaid Fraction
- Issue 8: Outlier Payments – Fixed Loss Threshold

On May 22, 2017, the Provider transferred Issues 2, 3, 4, 6, 7, and 8 to group appeals. Issue 1 was dismissed by the Board on April 26, 2022. The only remaining issue is Issue 5 – DSH Medicaid Eligible Days.

On February 10, 2022, the Provider filed its final position paper ("FPP"). The Provider's FPP essentially contends in its briefing of Issue 5 that additional Medicaid eligible days are required to be added to the Medicaid fraction; however, the FPP did not identify the alleged days in dispute (either by identifying how many or including a listing). Rather, the FPP states that a listing would be sent under separate cover.

On March 25, 2022, the Medicare Contractor filed a Motion to Dismiss Issue 1, the Medicaid Eligible Days issue, arguing that the Provider has effectively abandoned the issue by failing to furnish in its FPP any documentation in support of its claim for additional Medicaid Eligible Days or describe in its FPP why such documentation was and continues to be unavailable. Similarly, the Provider failed to respond to the Medicare Contractor's February 21, 2022 request for a listing of the additional Medicaid eligible days referenced in the Provider's FPP as being forthcoming. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. The Medicare Contractor claims that no listing has ever been provided in the 66 months since the appeal was filed.

The Provider has not, to date, filed a response to the Medicare Contractor's Motion to Dismiss. Board Rule 44.3 gave the Provider 30 days to respond to the Motion:

> Unless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and the opposing party.

Controlling Regulations and Board Rules

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Jul. 2015) states:

> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Similarly, with regard to position papers,[1] Board Rule 25.2.1 requires that "the parties must exchange ***all*** available documentation as exhibits to fully support your position." [2]

[1] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* PRRB Rule 27.2.
[2] (Emphasis added).

Board Rule 25.2.2 provides the following instruction on the content of position papers:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[3]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

> - if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
> - upon failure of the provider or group to comply with Board procedures,

[3] (Emphasis added).

- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

Decision of the Board

The Board concurs with the Medicare Contractor that the Provider is required to provide documentation to prove the additional Medicaid Eligible days to which it may be entitled. Pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed" [4] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, and noting that the Provider has been provided sufficient opportunity to rebut the Medicare Contractor's claims,[5] the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation in its FPP (or any other filing) as to why the documentation was absent or what is being done to obtain it, notwithstanding its obligation to do so under Board Rules.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[6] In this regard, the Board notes that the Provider represented in its FPP filed on February 10, 2022 that "the Listing of Medicaid Eligible days [was] being sent under separate cover."[7] However, no such listing has ever been received by either the Board or the Medicare Contractor (notwithstanding the Provider's representation that such a listing was available and ready and its now-ironic "request[] that the MAC review the Medicaid eligible days listing being sent under separate cover and provide a sample listing as soon as practicable"). Indeed, the Medicare Contractor represents that it followed up by email on February 21, 2022 requesting the listing of Medicaid eligible days that was promised but received no response. The Board notes that this appeal has been pending for nearly seven (7) years and that the Provider failed to respond to the Medicare Contractor's Motion to Dismiss within the 30 days allotted under Board Rule 44.3.

As such, the Board hereby dismisses Issue 5, the DSH Medicaid Eligible Days issue, from the appeal. As this was the last remaining issue in the appeal, the Board hereby closes Case No. 16-2521 and removes it from the Board's docket.

---

[4] (Emphasis added).
[5] *See* Board Rule 44.3.
[6] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[7] Final Position Paper at 11.

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

Board Members Participating:

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

For the Board:

5/5/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nina Marsden, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Ste 1600
Los Angeles, CA 90067

RE: ***Corrected EJR Determination***[1]
MHS 2008 Dual Eligible CIRP Group
Case No. 14-3909GC

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 28, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal. The decision of the Board to *deny* EJR is set forth below.

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

By letter dated April 25, 2022, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group case consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On March 22, 2022, subsequent to the submission of the EJR request in this appeal, the Board notified you of the relevance of Alert 19 to the EJR request. In particular, the Board notified you of the following:

> As the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under" the PRRB statute, which is a necessary jurisdictional prerequisite for a case to

[1] The Board is reissuing its EJR determination to correct typos/errors on the pages 16 and 17 and to attach the Schedule of Providers.

> eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b).

In this regard, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "***only if*** . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days ***after*** finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete."[2] Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[3]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. The issuance of this determination completes the Board jurisdictional review process and the Board is concurrently issuing its determination on the EJR request as the Board is familiar with the legal issues raised in the EJR request and has previously issued similar EJR determinations for those legal issues.

Issue in Dispute

The two providers used to establish this CIRP group are: (1) Long Beach Memorial Medical Center ("Memorial"); and (2) Community Hospital of Long Beach ("Community") (collectively hereinafter "Founding Providers"). The Founding Providers initially filed transfer requests to join the CIRP group under Case No. 09-2332GC entitled "MHS 10/1/2004-2007 Dual Eligible CIRP Group." However, by letter dated August 12, 2014, the Board found that the requested transfers were outside the fiscal years approved for Case No. 09-2332GC, and it denied expansion of that CIRP group.[4] As a result of these rulings, the Board, therein, took the

[2] (Emphasis added.)
[3] (Emphasis added.)
[4] Board Letter re: Requests to Transfer Providers into MHS 10/1/2004-2007 Dual Eligible CIRP Group, Case No. 09-2332GC (Aug. 12, 2014). The Board notes that Case No. 09-2332GC is still open and pending before the Board. Case No. 09-2332GC originally included DSH dual eligible days for discharges prior to October 1, 2004 but, in October 2013, the Board bifurcated those pre-October 1, 2004 days into Case No. 13-3960GC. Indeed, Case No. 09-2332GC was formed on or about September 14, 2009 and appears to be a bifurcation from (or, at a minimum, related

alterative action of establishing the instant single-year CIRP group covering 2008 under Case No. 14-3909GC.[5]

As no group issue statement was filed to establish the instant CIRP group (and the providers were not transferring from a group), the issue transferred by the Founding Providers from their respective individual appeals, governs the group issue statement. Here, the Founding Providers each had the same issue statement in their individual appeals for the issue that they transferred to the instant CIRP group. That issue statement reads as follows:

> ISSUE: Dual eligible days *excluded from the Medicaid **and** SSI ratios*.
>
> BRIEF DESCRIPTION: Whether the MAC utilized the appropriate Medicaid and/or SSI ratios in the calculation of the DSH and LIP adjustments as *dual eligible days were excluded from **both** ratios*.
>
> . . . .
>
> BASIS FOR APPEAL: 42 C.F.R. § 412.106(b), 412.320 and 412.624(e)
>
> Dual eligible days are patient days associated with those patients who were ***not** included in the SSI denominator by CMS' design* as they were not directly billed to Medicare and did not flow through the [MEDPAR] system. ***These days*** are disallowed as "Medicare eligible" by the MAC from the Medicaid numerator. Hence,

---

to) Case No. 09-2176GC entitled "MHS 1996 – 2003 DSH Dual Eligibles CIRP Group," which was established via an appeal request filed on August 26, 2009 that included certain FY 2004 providers that ultimately ended up in Case No. 09-2332GC. As explained in CMS Ruling 1498-R, CMS' policy prior to October 1, 2004 was to exclude no-pay Part-A days (including the subset associated with dual eligible) from both the Medicare and Medicaid fractions:

> Hospitals have also filed DSH appeals to the PRRB challenging the **exclusion** from the DPP of non-covered inpatient hospital days for patients entitled to Medicare Part A, including appeals of days for which the patient's Part A hospital benefits were exhausted. Under CMS' original policy, inpatient days were included in the numerator of the DSH SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the SSI fraction. *See, e.g.*, 42 C.F.R. § 412.106(b)(2)(i) (2003). CMS' original policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were **excluded** from the numerator of the DSH Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days in its Medicare cost report). *See* 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004) ("FY 2005 IPPS final rule").

CMS Ruling 1498-R at 7-8 (Apr. 28, 2010) (bold emphasis added).

[5] *Id.* The Board notes that, as part of this correspondence, the Board also denied other transfer requests relating to other years and the Board similarly established MHS CIRP groups for these other years.

> *neither the Medicaid fraction nor the Medicare fraction captured the days associated with this indigent population.*
>
> Dual eligible days were excluded from the Medicaid fraction for a variety of reasons. By way of example, some dual eligible days are associated with patients who are eligible for Medicaid by have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL) v. Blue Cross and Blue Shield Association . . . , PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held:
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. [citations omitted].
>
> Thus, in accordance with the Board's holding in Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days". . . .[6]

In contrast, the EJR request for the CIRP group frames the legal question as follows:

> The Group Appeal challenges the regulation and policy of [CMS], promulgated as part of the FY 2005 IPPS Final Rule, to count exhausted or otherwise non-covered days for patients eligible for Medicare *in the Medicare/SSI fraction* and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction, as adopted and applied by CMS for purposes of calculating the Hospitals' Medicare [DSH] payments during their respective fiscal years included in the Group Appeal.[7]

The following excerpts from this EJR request shed additional light on the nature of this legal question:

- "As Section III below shows, the Hospitals are challenging the validity of CMS's regulation and policy to count exhausted or otherwise non-covered days for patients eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction."[8]

- "Part A exhausted or noncovered days should, for dually-eligible patients, be ***included*** *in the numerator of the Medicaid fraction,* ***and*** ***excluded*** *from the*

[6] *E.g.*, PRRB Case 13-3145, Individual Appeal Request, Issue 7 (Aug. 21, 2013) (emphasis added).
[7] Request for Expedited Judicial Review, 1-2 (Mar. 28, 2022) ("EJR Request").
[8] *Id.* at 2 (emphasis added).

Medicare/SSI fraction, because, by definition, those days relate to patients who were not 'entitled to' Medicare Part A benefits 'for such days' when the services were provided. Part A exhausted days and noncovered days should be excluded from the Medicare/SSI fraction for the same reason."[9]

- "Accordingly, CMS's regulation and policy requiring *including* Part A exhausted and other noncovered days in the Medicare/SSI fraction, ***and*** *excluding* such days from the numerator of the Medicaid fraction for dually-eligible patients, are 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,' 5 U.S.C. §706(2)(A), 'in excess of statutory jurisdiction, authority, or limitations, or short of statutory right,' id. §706(2)(C), and/or were not promulgated in accordance with applicable notice and comment requirements under, 42 U.S.C. §1395hh and/or 5 U.S.C. §553."[10]

Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[11] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[12]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[13] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[14]

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

---

[9] *Id.* at 5 (emphasis added).
[10] *Id.* at 6 (emphasis added.)
[11] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[12] *Id.*
[13] *See* 42 U.S.C. § 1395ww(d)(5).
[14] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[15] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[16] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[17] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

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 . . . .[18]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[19]

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.[20]

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.[21]

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

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[22] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid

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

fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[23]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[24] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[25] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[26]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[27] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[28] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[29]

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

---

[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.* at 27207-27208.
[27] *Id.* at 27207-08.
[28] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[29] 68 Fed. Reg. at 27208.
[30] *Id.*
[31] *Id.*

would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[32]

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

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[35] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

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

[32] *Id.*
[33] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[34] *Id.*
[35] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[36] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).

> A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[37]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[38] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[39] Prior to this revision, § 412.106(b)(2) (2004) had stated:

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

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

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that--*
>
> (A) Are associated with discharges occurring during each month; and

[37] *Id.* at 49099 (emphasis added).
[38] *Id.*
[39] *See id.* at 49099, 49246.
[40] (Emphasis added.)

> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[41]

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

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[43] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[44]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[45] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[46] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures

---

[41] (Emphasis added.)
[42] *Id.*
[43] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).
[44] (Citations omitted and emphasis added.)
[45] 317 F. Supp. 3d 168 (D.D.C. 2018).
[46] *Id.* at 172.

and that the rule is *not* procedurally defective.[47] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[48] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[49] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[50] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[51] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[52]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[53] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[54] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[55] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[56] and that the regulation is procedurally invalid.[57]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[58] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[59] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's

[47] *Id.* at 190.
[48] *Id.* at 194.
[49] *See* 2019 WL 668282.
[50] 718 F.3d 914 (2013).
[51] 657 F.3d 1 (D.C. Cir. 2011).
[52] 718 F.3d at 920.
[53] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[54] *Id.* at 1141.
[55] *Id.*
[56] *Id.* at 1162.
[57] *Id.* at 1163
[58] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[59] *Id.* at 884.

procedural requirements."[60] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[61] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[62] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[63] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[64] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[65] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

Providers' Position

Issue Outlined in the EJR Request for the CIRP Group

The Providers in the CIRP group requested EJR to challenge the inclusion of certain Part A non-covered (*e.g.*, Part A exhausted) patient days in the Medicare fraction of the DSH calculation. The Providers argue that CMS has been inconsistent with the treatment of days for Medicare inpatients who have exhausted their Part A benefits or whose days have otherwise not been paid (Part A exhausted and other non-covered days). They note that, while historically these days were not counted in the Medicare fraction, CMS proposed in the FY 2004 IPPS Proposed Rule to count the days for patients who were dually-eligible in the numerator of the Medicaid fraction. However, CMS did not enact this proposal. Rather, in the FY 2005 IPPS Final Rule, CMS

[60] *Id.* at 884.
[61] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[62] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[63] *Id.* at 886.
[64] *Id.*
[65] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

finalized the opposite policy: Part A exhausted and non-covered days would be counted in the Medicare fraction, and these days would be excluded from dual-eligible days in the Medicaid fraction numerator. The Providers assert that this policy change resulted in those exhausted non-covered days associated with dually eligible patients being excluded from the Medicaid fraction's numerator and only potentially being included in the Medicare fraction's numerator.[66]

The Providers contend that the policy adopted in the FY 2005 IPPS Final Rule and the associated regulatory changes were substantively and/or procedurally invalid. They claim that these no-pay Part A days should be included in the numerator of the Medicaid fraction (for the subset of those days associated with dually-eligible patients) and excluded in full from the Medicare fraction (both the numerator and denominator) because these days relate to patients who were not "entitled to" Part A benefits "for such days" when the services were provided. They state that CMS' policy deserves no deference. They contend that CMS misstated both its current and proposed policies in its FY 2004 and 2005 rulemaking, failed to provide adequate notice and opportunity for comment, and has interpreted "entitled to benefits under [Medicare Part A]" for purposes of the DSH fractions in a manner inconsistent with the statute and precedent. They note that the Ninth Circuit's decision in *Empire Health Foundation v. Azar* vacated the regulation at issue.[67] The Providers maintain EJR is appropriate because the regulation was held to be invalid and is being reviewed by the Supreme Court, and because the Board lacks the authority to review the validity of a regulation.[68]

Issue Appealed by the CIRP Group

As previously noted, this CIRP group was created after the Founding Providers sought to transfer Dual Eligible days issues from several individual appeals and the group issue for this CIRP group was set based on the issue transferred by the Founding Providers.[69] In the individual appeals, the stated issue is simply stated as "Dual eligible days excluded from the Medicaid ***and*** SSI Ratios."[70] The "Basis for Appeal," thus, appears to describe CMS' pre-October 1, 2004 policy (*i.e.*, the policy in effect prior to the FY 2005 IPPS Final Rule) to exclude no-pay Part A days (including days associated with patients who were dual eligibles) from ***both*** the Medicare fraction and the Medicaid fraction.[71] Indeed, the appealed issue states that it pertains to those days that "were not included in the SSI [*i.e.*, Medicare] denominator by design" (*i.e.*, no pay dual eligible days) and were "disallowed . . . from the Medicaid numerator. Hence, ***neither*** *the Medicaid fraction* ***nor*** *the Medicare fraction captured the days associated with this indigent population.*"[72] In support of their position, the Providers cite to *Edgewater Med. Ctr. v. Blue*

[66] EJR Request at 4-5.
[67] *Id.* at 6 (citing to 958 F.3d 873 (9th Cir. 2020).
[68] *Id.* at 5-6.
[69] Board Letter re: Requests to Transfer Providers into MHS 10/1/2004-2007 Dual Eligible CIRP Group, Case No. 09-2332GC (Aug. 12, 2014).
[70] (Emphasis added.)
[71] *See* CMS Ruling 1498-R2 at 3 (Apr. 22, 2015); CMS Ruling 1498-R at 7-8 (Apr. 28, 2010). The relationship of this appeal to other MHS CIRP cases with pre-2004 fiscal years challenging CMS' policy in effect prior to the changes made in the FY 2005 IPPS Final Rule supports this conclusion. *See supra* note 4.
[72] (Emphasis added).

Cross and Blue Shield Ass'n,[73] a Board decision issued in 2000 which involved a provider's 1990 fiscal year and clearly predates the dual eligible days policy enacted in FY 2005 IPPS Final Rule, which is the subject of the instant EJR Request.

Decision of the Board

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

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [74]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[75]

For an issue to be added to an existing appeal, the request for addition must comply with the same requirements for requesting a Board hearing in an initial appeal.[76] When the underlying individual appeals were filed, the Board Rules (Mar. 1, 2013) required Providers to, for each issue under appeal, provide the basis for dissatisfaction with its final determination. With regard to identifying the issue, Providers were required to provide an issue statement that described the adjustment, ***why the adjustment was incorrect***, and how the payment should be determined differently.[77] Similarly, the regulation at 42 C.F.R. § 405.1835(b) (2013) stated:

> (b) *Contents of request for a Board hearing*. The provider's request for *a Board hearing* must be submitted in writing to the Board, and the request **must include the elements** described in paragraphs (b)(1) through (b)(4) of this section. If the provider

[73] PRRB Dec. 2000-D44 (Apr. 7, 2000).
[74] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[75] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[76] 42 C.F.R. § 405.1835(e).
[77] PRRB Rule 7 (Mar. 1, 2013) (emphasis added). *See also* Board Rule 8 (stating "Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7." (emphasis added)).

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

Failure to meet these requirements permits the Board to dismiss the issue with prejudice or take any other remedial action it considers appropriate.[78] A request to add an additional issue is timely made if received by the Board no later than 240 days after the date of a final determination.[79]

The Board finds that the Providers in this CIRP group have appealed only those "dual eligible days" that it alleges were excluded from ***both*** the Medicare fraction ***and*** the Medicare fraction (as reflected in the CMS policy predating the FY 2005 IPPS Final Rule).[80] The issue statements used to form the group do not refer to no-pay Part A days such as exhausted days or Medicare secondary payor ("MSP") days. In this regard, the Board notes that a reference to "dual eligible

---

[78] 42 C.F.R. § 405.1835(b).
[79] 42 C.F.R. § 405.1835(c)(3) (2013).
[80] The issue statement associated with the individual appeals that established the group appeal clearly defines the term "dual eligible days" as used therein as those days that "were not included in the SSI [*i.e.*, Medicare] denominator by CMS' design" where "***[t]hese*** *days* were [also] disallowed as 'Medicare eligible' by the MAC from the Medicaid numerator." (Emphasis added.) The relationship of this appeal to other MHS CIRP cases appealing this same class of days and challenging CMS' policy in effect prior to the changes made in the FY 2005 IPPS Final Rule support this conclusion. *See supra* note 4. Similarly, the only authority cited by the Providers in their issue statement is the Board's 2000 decision in *Edgewater* which, as discussed *supra*, clearly involved and applied the pre-October 1, 2004 policy.

days" for a hospital's fiscal year is clearly different than no-pay Part A days where the underlying patients associated with those days across a fiscal year largely were not Medicaid eligible and only a subset of those patients were Medicaid eligible.

In contrast, the EJR request concerns the FY 2005 IPPS Final Rule and challenges CMS' policy set forth therein to count *all* no-pay Part A days in the Medicare fraction effective for discharges on or after October 1, 2004 and seeks to include the subset of those days for which the underlying patients were also Medicaid eligible in the numerator of the Medicaid fraction. Any challenge to that policy would necessarily be a separate and distinct issue from the one appealed in the issue statement for this CIRP group. As such, the Board finds that the Providers' EJR request attempts to add issues to this CIRP group, namely: (1) the exclusion of all no-pay part A days from the Medicare fraction; and (2) the inclusion of the ***subset*** of those days, for which the underlying patients were also Medicaid eligible (*i.e.*, were dually eligible), in the numerator of the Medicaid fraction. However, 42 C.F.R. § 405.1837(f)(1) makes clear that issues may *not* be added to a group appeal after the group hearing request is filed. As such, the Board finds that it lacks jurisdiction in these appeals over the ***specific*** issue sought in its EJR Request because it was not included in the original appeals, and, since jurisdiction is a prerequisite to granting EJR, the Board hereby ***denies*** the EJR Request for Case No. 14-3909GC.

Finally, the Board notes that one requirement for Board jurisdiction over a group is that the group have, in the aggregate, at least $50,000 or more in controversy as specified in 42 C.F.R. § 405.1840(a). Here, each of the Providers participating in the instant CIRP group did not include a specific amount in controversy for the issue that they transferred to the instant CIRP group.[81] Thus, for purpose of demonstrating that they met the minimum $50,000 amount in controversy for purposes of forming a group, the Providers included in the final Schedule of Providers a calculation of the estimated amount in controversy for each Provider. Each of those calculations is dated March 18, 2022 and, less than 4 weeks later, the Providers filed the instant EJR request on April 13, 2022. Thus, it is clear that these estimates were prepared in anticipation of the instant EJR request and a review of these estimates demonstrates that they relate *only* to the issue for which the Providers seek EJR (as opposed to the issue that was originally appealed and used to form the group). Specifically, each of these estimates shows the "[p]otential impact of using covered days (per CMS) with the decrease in SSI days added to Medi-Cal." For example, the estimated amount in controversy included for Memorial at Tab 2E of the Schedule of Providers shows Memorial's DSH payment would increase by an estimated $103,688 due to: (1) a *decrease* in the Medicare fraction from 14.89 percent to 14.84 percent by *removing* no pay Part A days (as relevant, from both the numerator and denominator of the Medicare fraction) so that only "covered days" remain; and (2) an increase in the number of Medi-Cal Eligible days from 18,799 to 19,034 as used in the numerator of the Medicaid fraction. Thus, these estimates all clearly show either an increase or decrease to the Medicare fraction (by removing any no-pay Part A days, as relevant, from the numerator and denominator of the Medicare fraction[82]) and an increase

[81] The individual appeals for each of these providers included multiple issues and, rather than giving an amount in controversy for each issue, each provider relied on the issues in the aggregate to meet the minimum $10,000 amount in controversy required for an individual appeal. *See* 42 C.F.R. § 405.1839(a)(2).

[82] Whether the removal of the no-pay Part A days results in a decrease versus an increase in the Medicare fraction depends on how many of these days involve patients who are also SSI recipients since the subset of days associated

to the Medicaid fraction (by including in the numerator of the Medicaid fraction the subset of those removed days that pertain to dual eligibles). In contrast, the issue statement used to form the CIRP group relates *only* to the class of dual eligible days that were excluded from ***both*** the Medicare and Medicaid fractions (*i.e.*, the days at issue are only those dual eligible days excluded from the Medicare and Medicaid fractions) and, as such, the Medicare fraction would never reflect a change (increase or decrease) for purposes of calculating an estimated amount in controversy *based on the issue statement used to form the CIRP group*.[83] Based on the above findings, it is clear that the record for the *fully-formed* group does not contain any estimated amount in controversy *for the group issue for which it was formed*.

Pursuant to 42 C.F.R. § 405.1837(a)(3), the amount in controversy for a group is determined in accordance with § 405.1839, which states, in pertinent part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under §405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000.
>
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues.
>
> (A) A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in §405.1837(a)(2) of this subpart).
>
> (B) The single issue that is common to each provider may exist over different cost reporting periods.
>
> (ii) For purposes of satisfying the amount in controversy requirement, a provider may appeal multiple cost reporting periods and different providers in the group may appeal different cost reporting periods.

---

with these SSI recipients are removed not only from the denominator of the Medicare fraction but also from the numerator of the Medicare fraction.

[83] Moreover, the Board notes that the CMS policy in effect *during the time at issue in this CIRP group* was to count all no-pay Part A days in the Medicare fraction (including those associated with patients who were also Medicaid eligible). Accordingly, if an amount in controversy had been calculated for the class of days *covered by the group issue statement* (*i.e.*, those dual eligible days that were excluded from ***both*** the Medicare *and* Medicaid fractions), it would appear that the amount in controversy for this CIRP group would be close to zero (*i.e.*, below the minimum $50,000 threshold) since, under that policy, there would be no dual eligible days excluded from both the Medicare and Medicaid fractions during the years at issue. To the extent any dual eligible days were, ***in fact***, excluded from both fractions (as alleged but yet contrary to that policy), then that would be a factual issue and would presumably be similar to the systemic data match issues raised in the *Baystate* litigation. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, Adm'r Dec. (May 11, 2006); *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008).

In addition, § 405.1837(e)(2) makes clear that the Board may consider dismissing a group appeal hearing request for failure to meet that requirement once the group is *fully formed*.

Here, it is clear that the CIRP group is ***fully formed*** and that the Providers have failed to demonstrate that they meet the $50,000 amount in controversy requirement *for the issue covered by the group*. Rather, they have attempted to add an issue to the group and, in the documentation submitted to demonstrate the Board's jurisdiction over this group, they have alleged an amount in controversy for this added issue. As previously noted, adding issues to group appeals is prohibited by regulation. As the group is fully formed and the providers have failed to establish they meet the amount in controversy *for the issue appealed by the group*, the Board hereby dismisses the group appeal pursuant to its authority under 42 C.F.R. §§ 405.1837(e)(2) and 42 C.F.R. § 405.1868(b)(2).

Further, the facts that a group appeal may contain only one issue and that the EJR request, along with estimated amounts in controversy, were submitted on an issue other than the one for which the group appeal was established, the Board must conclude that the Providers have abandoned the original group issue. This serves as an alternate, and independent, basis for dismissal.[84]

* * * * *

In summary, the Board denies the EJR request and dismisses the CIRP group (including all the remaining participants therein, as shown on the attached Schedule of Providers). Accordingly, the Board closes this CIRP group and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

5/5/2022

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS

[84] This is analogous to Board Rules governing position papers which specify that "If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Board Rule 25.3 (Nov. 2021). Further Board Rule 41.2 specifies:

> The Board may dismiss a case or an issue on its own motion:
> - If it has a reasonable basis to believe that the issues have been fully settled or abandoned:
> - Upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868); . . . .

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nina Marsden, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Ste 1600
Los Angeles, CA 90067

RE: ***EJR Determination***
MHS 2010 Dual Eligible CIRP Group
Case No. 14-3912GC

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 28, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal. The decision of the Board to *deny* EJR is set forth below.

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

By letter dated April 25, 2022, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group case consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On March 22, 2022, subsequent to the submission of the EJR request in this appeal, the Board notified you of the relevance of Alert 19 to the EJR request. In particular, the Board notified you of the following:

> As the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under" the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b).

In this regard, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "***only if*** . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days ***after*** finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete."[1] Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[2]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. The issuance of this determination completes the Board jurisdictional review process and the Board is concurrently issuing its determination on the EJR request as the Board is familiar with the legal issues raised in the EJR request and has previously issued similar EJR determinations for those legal issues.

Issue in Dispute

The provider used to establish this CIRP group was Orange Coast Memorial Medical Center (hereinafter "Orange Coast" or "Founding Provider"). The Founding Provider initially filed a transfer request to join the CIRP group under Case No. 09-2332GC entitled "MHS 10/1/2004-2007 Dual Eligible CIRP Group." However, by letter dated August 12, 2014, the Board found that the requested transfer was outside the fiscal years approved for Case No. 09-2332GC, and it denied expansion of that CIRP group.[3] As a result of these rulings, the Board, therein, took the

---

[1] (Emphasis added.)
[2] (Emphasis added.)
[3] Board Letter re: Requests to Transfer Providers into MHS 10/1/2004-2007 Dual Eligible CIRP Group, Case No. 09-2332GC (Aug. 12, 2014). The Board notes that Case No. 09-2332GC is still open and pending before the Board. Case No. 09-2332GC originally included DSH dual eligible days for discharges prior to October 1, 2004 but, in October 2013, the Board bifurcated those pre-October 1, 2004 days into Case No. 13-3960GC. Indeed, Case No. 09-2332GC was formed on or about September 14, 2009 and appears to be a bifurcation from (or, at a minimum, related to) Case No. 09-2176GC entitled "MHS 1996 – 2003 DSH Dual Eligibles CIRP Group," which was established via an appeal request filed on August 26, 2009 that included certain FY 2004 providers that ultimately ended up in Case No. 09-2332GC. As explained in CMS Ruling 1498-R, CMS' policy prior to October 1, 2004 was to exclude no-pay Part-A days (including the subset associated with dual eligible) from both the Medicare and Medicaid fractions:

alterative action of establishing the instant single-year CIRP group covering 2010 under Case No. 14-3912GC.[4]

As no group issue statement was filed to establish the instant CIRP group (and the provider was not transferring from a group), the issue transferred by the Founding Provider from its respective individual appeal governs the group issue statement. That issue statement reads as follows:

> ISSUE: Dual eligible days *excluded from the Medicaid **and** SSI ratios*.
>
> BRIEF DESCRIPTION: Whether the MAC utilized the appropriate Medicaid and/or SSI ratios in the calculation of the DSH and LIP adjustments as *dual eligible days were excluded from **both** ratios*.
>
> . . . .
>
> BASIS FOR APPEAL: 42 C.F.R. § 412.106(b), 412.320 and 412.624(e)
>
> Dual eligible days are patient days associated with those patients who were ***not** included in the SSI denominator by CMS' design* as they were not directly billed to Medicare and did not flow through the [MEDPAR] system. ***These days*** are disallowed as "Medicare eligible" by the MAC from the Medicaid numerator. Hence, *neither the Medicaid fraction nor the Medicare fraction captured the days associated with this indigent population.*
>
> Dual eligible days were excluded from the Medicaid fraction for a variety of reasons. By way of example, some dual eligible days are associated with patients who are eligible for Medicaid by have

---

> Hospitals have also filed DSH appeals to the PRRB challenging the **exclusion** from the DPP of non-covered inpatient hospital days for patients entitled to Medicare Part A, including appeals of days for which the patient's Part A hospital benefits were exhausted. Under CMS' original policy, inpatient days were included in the numerator of the DSH SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the SSI fraction. *See, e.g.*, 42 C.F.R. § 412.106(b)(2)(i) (2003). CMS' original policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were **excluded** from the numerator of the DSH Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days in its Medicare cost report). *See* 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004) ("FY 2005 IPPS final rule").

CMS Ruling 1498-R at 7-8 (Apr. 28, 2010) (bold emphasis added).

[4] *Id.* The Board notes that, as part of this correspondence, the Board also denied other transfer requests relating to other years and the Board similarly established MHS CIRP groups for these other years.

> exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL) v. Blue Cross and Blue Shield Association . . . , PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held:
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. See Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Case No. 99-D4 [full citations omitted].
>
> Thus, in accordance with the Board's holding in Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days". . . .[5]

In contrast, the EJR request for the CIRP group frames the legal question as follows:

> The Group Appeal challenges the regulation and policy of [CMS], promulgated as part of the FY 2005 IPPS Final Rule, to count exhausted or otherwise non-covered days for patients eligible for Medicare *in the Medicare/SSI fraction* and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction, as adopted and applied by CMS for purposes of calculating the Hospitals' Medicare [DSH] payments during their respective fiscal years included in the Group Appeal.[6]

The following excerpts from this EJR request shed additional light on the nature of this legal question:

- "As Section III below shows, the Hospitals are challenging the validity of CMS's regulation and policy to count exhausted or otherwise non-covered days for patients eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction."[7]

- "Part A exhausted or noncovered days should, for dually-eligible patients, be ***included*** *in the numerator of the Medicaid fraction,* ***and*** ***excluded*** *from the Medicare/SSI fraction*, because, by definition, those days relate to patients who were not 'entitled to' Medicare Part A benefits 'for such days' when the services were

[5] PRRB Case 14-0143, Individual Appeal Request, Issue 7 (Oct. 17, 2013) (emphasis added).
[6] Request for Expedited Judicial Review, 1-2 (Mar. 28, 2022) ("EJR Request").
[7] *Id.* at 2 (emphasis added).

provided. Part A exhausted days and noncovered days should be excluded from the Medicare/SSI fraction for the same reason."[8]

- "Accordingly, CMS's regulation and policy requiring *including* Part A exhausted and other noncovered days in the Medicare/SSI fraction, ***and*** *excluding* such days from the numerator of the Medicaid fraction for dually-eligible patients, are 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,' 5 U.S.C. §706(2)(A), 'in excess of statutory jurisdiction, authority, or limitations, or short of statutory right,' id. §706(2)(C), and/or were not promulgated in accordance with applicable notice and comment requirements under, 42 U.S.C. §1395hh and/or 5 U.S.C. §553."[9]

Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[14] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[15] The DPP is defined as the sum of two fractions expressed as percentages.[16] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which

[8] *Id*. at 5 (emphasis added).
[9] *Id*. at 6 (emphasis added.)
[10] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[11] *Id*.
[12] *See* 42 U.S.C. § 1395ww(d)(5).
[13] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[14] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[15] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[16] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[17]

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[19]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[20]

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

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

---

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

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[23] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[24] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[25]

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

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

---

[23] *Id.*
[24] *Id.*
[25] *Id.* at 27207-27208.
[26] *Id.* at 27207-08.
[27] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[28] 68 Fed. Reg. at 27208.
[29] *Id.*
[30] *Id.*
[31] *Id.*

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[32] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[33]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[34] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently *misstated* our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[35]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the*

[32] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[33] *Id.*
[34] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[35] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).

> *days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[36]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[37] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[38] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[39]

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

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

---

[36] *Id.* at 49099 (emphasis added).
[37] *Id.*
[38] *See id.* at 49099, 49246.
[39] (Emphasis added.)
[40] (Emphasis added.)

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[41]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[42] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[43]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[44] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[45] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[46] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[47] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit");

---

[41] *Id.*
[42] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).
[43] (Citations omitted and emphasis added.)
[44] 317 F. Supp. 3d 168 (D.D.C. 2018).
[45] *Id.* at 172.
[46] *Id.* at 190.
[47] *Id.* at 194.

however, the D.C. Circuit later dismissed it.[48] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[49] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[50] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[51]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[52] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[53] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[54] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[55] and that the regulation is procedurally invalid.[56]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[57] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[58] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[59] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in

[48] *See* 2019 WL 668282.
[49] 718 F.3d 914 (2013).
[50] 657 F.3d 1 (D.C. Cir. 2011).
[51] 718 F.3d at 920.
[52] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[53] *Id.* at 1141.
[54] *Id.*
[55] *Id.* at 1162.
[56] *Id.* at 1163
[57] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[58] *Id.* at 884.
[59] *Id.* at 884.

Legacy Emanuel Hospital and Health Center v. Shalala ("*Legacy Emanuel*")[60] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[61] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[62] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[63] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[64] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

Providers' Position

Issue Outlined in the EJR Request for the CIRP Group

The Providers in the CIRP group requested EJR to challenge the inclusion of certain Part A non-covered (*e.g.*, Part A exhausted) patient days in the Medicare fraction of the DSH calculation. The Providers argue that CMS has been inconsistent with the treatment of days for Medicare inpatients who have exhausted their Part A benefits or whose days have otherwise not been paid (Part A exhausted and other non-covered days). They note that, while historically these days were not counted in the Medicare fraction, CMS proposed in the FY 2004 IPPS Proposed Rule to count the days for patients who were dually-eligible in the numerator of the Medicaid fraction. However, CMS did not enact this proposal. Rather, in the FY 2005 IPPS Final Rule, CMS finalized the opposite policy: Part A exhausted and non-covered days would be counted in the Medicare fraction, and these days would be excluded from dual-eligible days in the Medicaid fraction numerator. The Providers assert that this policy change resulted in those exhausted non-

[60] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[61] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[62] *Id.* at 886.
[63] *Id.*
[64] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

covered days associated with dually eligible patients being excluded from the Medicaid fraction's numerator and only potentially being included in the Medicare fraction's numerator.[65]

The Providers contend that the policy adopted in the FY 2005 IPPS Final Rule and the associated regulatory changes were substantively and/or procedurally invalid. They claim that these no-pay Part A days should be included in the numerator of the Medicaid fraction (for the subset of those days associated with dually-eligible patients) and excluded in full from the Medicare fraction (both the numerator and denominator) because these days relate to patients who were not "entitled to" Part A benefits "for such days" when the services were provided. They state that CMS' policy deserves no deference. They contend that CMS misstated both its current and proposed policies in its FY 2004 and 2005 rulemaking, failed to provide adequate notice and opportunity for comment, and has interpreted "entitled to benefits under [Medicare Part A]" for purposes of the DSH fractions in a manner inconsistent with the statute and precedent. They note that the Ninth Circuit's decision in *Empire Health Foundation v. Azar* vacated the regulation at issue.[66] The Providers maintain EJR is appropriate because the regulation was held to be invalid and is being reviewed by the Supreme Court, and because the Board lacks the authority to review the validity of a regulation.[67]

Issue Appealed by the CIRP Group

As previously noted, this CIRP group was created after the Founding Provider sought to transfer its Dual Eligible days issue from an individual appeal and the group issue for this CIRP group was set based on the issue transferred by the Founding Provider.[68] In the individual appeal, the stated issue is simply stated as "Dual eligible days excluded from the Medicaid ***and*** SSI Ratios."[69] The "Basis for Appeal," thus, appears to describe CMS' pre-October 1, 2004 policy (*i.e.*, the policy in effect prior to the FY 2005 IPPS Final Rule) to exclude no-pay Part A days (including days associated with patients who were dual eligibles) from ***both*** the Medicare fraction and the Medicaid fraction.[70] Indeed, the appealed issue states that it pertains to those days that "were not included in the SSI [*i.e.*, Medicare] denominator by design" (*i.e.*, no pay dual eligible days) and were "disallowed . . . from the Medicaid numerator. Hence, ***neither*** *the Medicaid fraction* ***nor*** *the Medicare fraction captured the days associated with this indigent population.*"[71] In support of its position, the Provider cites to *Edgewater Med. Ctr. v. Blue Cross and Blue Shield Ass'n*,[72] a Board decision issued in 2000 which involved a provider's 1990 fiscal year and clearly predates the dual eligible days policy enacted in FY 2005 IPPS Final Rule, which is the subject of the instant EJR Request.

---

[65] EJR Request at 4-5.
[66] *Id.* at 6 (citing to 958 F.3d 873 (9th Cir. 2020).
[67] *Id.* at 5-6.
[68] Board Letter re: Requests to Transfer Providers into MHS 10/1/2004-2007 Dual Eligible CIRP Group, Case No. 09-2332GC (Aug. 12, 2014).
[69] (Emphasis added.)
[70] *See* CMS Ruling 1498-R2 at 3 (Apr. 22, 2015); CMS Ruling 1498-R at 7-8 (Apr. 28, 2010). The relationship of this appeal to other MHS CIRP cases with pre-2004 fiscal years challenging CMS' policy in effect prior to the changes made in the FY 2005 IPPS Final Rule supports this conclusion. *See supra* note 3.
[71] (Emphasis added).
[72] PRRB Dec. 2000-D44 (Apr. 7, 2000).

Decision of the Board

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

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [73]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[74]

For an issue to be added to an existing appeal, the request for addition must comply with the same requirements for requesting a Board hearing in an initial appeal.[75] When the underlying individual appeals were filed, the Board Rules (Mar. 1, 2013) required Providers to, for each issue under appeal, provide the basis for dissatisfaction with its final determination. With regard to identifying the issue, Providers were required to provide an issue statement that described the adjustment, ***why the adjustment was incorrect***, and how the payment should be determined differently.[76] Similarly, the regulation at 42 C.F.R. § 405.1835(b) (2013) stated:

> (b) *Contents of request for a Board hearing*. The provider's request for *a Board hearing* must be submitted in writing to the Board, and the request **must include the elements** described in paragraphs (b)(1) through (b)(4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraphs (b)(1), (b)(2), or (b)(3) of this section, **the Board may**

[73] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[74] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[75] 42 C.F.R. § 405.1835(e).
[76] PRRB Rule 7 (Mar. 1, 2013) (emphasis added). *See also* Board Rule 8 (stating "Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7." (emphasis added)).

> **dismiss with prejudice** the appeal, or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section . . . .
>
> (2) An explanation (for **each** specific item at issue, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for **each** disputed item (or where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to the underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.

Failure to meet these requirements permits the Board to dismiss the issue with prejudice or take any other remedial action it considers appropriate.[77] A request to add an additional issue is timely made if received by the Board no later than 240 days after the date of a final determination.[78]

The requirements for establishing a group appeal are similar. In this regard, 42 C.F.R. § 405.1837(c) (2014) addresses the content of a group appeal request:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) An explanation (for each specific item at issue; see §405.1835(a)(1)) of each provider's dissatisfaction with its

[77] 42 C.F.R. § 405.1835(b).
[78] 42 C.F.R. § 405.1835(c)(3) (2013).

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

The Board finds that the Providers in this CIRP group have appealed only those "dual eligible days" that it alleges were excluded from ***both*** the Medicare fraction ***and*** the Medicare fraction (as reflected in the CMS policy predating the FY 2005 IPPS Final Rule).[79] The issue statement used to form the group do not refer to no-pay Part A days of which exhausted days or Medicare secondary payor ("MSP") days are just a subset. In this regard, the Board notes that a reference to "dual eligible days" for a hospital's fiscal year is clearly different than no-pay Part A days

[79] The issue statement associated with the individual appeals that established the group appeal clearly defines the term "dual eligible days" as used therein as those days that "were not included in the SSI [*i.e.*, Medicare] denominator by CMS' design" where "***[t]hese*** *days* were [also] disallowed as 'Medicare eligible' by the MAC from the Medicaid numerator." (Emphasis added.) The relationship of this appeal to other MHS CIRP cases appealing this same class of days and challenging CMS' policy in effect prior to the changes made in the FY 2005 IPPS Final Rule support this conclusion. *See supra* note 3. Similarly, the only authority cited by the Providers in their issue statement is the Board's 2000 decision in *Edgewater* which, as discussed *supra*, clearly involved and applied the pre-October 1, 2004 policy.

where the underlying patients associated with those days across a fiscal year largely were not Medicaid eligible and only a subset of those patients were Medicaid eligible.

In contrast, the EJR request concerns the FY 2005 IPPS Final Rule and challenges CMS' policy set forth therein to count *all* no-pay Part A days in the Medicare fraction effective for discharges on or after October 1, 2004 and seeks to include the subset of those days for which the underlying patients were also Medicaid eligible in the numerator of the Medicaid fraction. Any challenge to that policy would necessarily be a separate and distinct issue from the one appealed in the issue statement for this CIRP group. As such, the Board finds that the Providers' EJR request attempts to add issues to this CIRP group, namely: (1) the exclusion of all no-pay part A days from the Medicare fraction; and (2) the inclusion of the ***subset*** of those days, for which the underlying patients were also Medicaid eligible (*i.e.*, were dually eligible), in the numerator of the Medicaid fraction. However, 42 C.F.R. § 405.1837(f)(1) makes clear that issues may *not* be added to a group appeal after the group hearing request is filed. As such, the Board finds that it lacks jurisdiction in these appeals over the ***specific*** issue sought in its EJR Request because it was not included in the original appeals in violation of the content-specificity requirements in 42 C.F.R. §§ 405.1835(b) and 405.1837(c), and, since jurisdiction is a prerequisite to granting EJR, the Board hereby ***denies*** the EJR Request for Case No. 14-3912GC.

Finally, the Board notes that one requirement for Board jurisdiction over a group is that the group have, in the aggregate, at least $50,000 or more in controversy as specified in 42 C.F.R. § 405.1840(a). Here, each of the Providers participating in the instant CIRP group did not include a specific amount in controversy for the issue that they transferred to the instant CIRP group.[80] Thus, for purpose of demonstrating that they met the minimum $50,000 amount in controversy for purposes of forming a group, the Providers included in the final Schedule of Providers a calculation of the estimated amount in controversy for each Provider. Each of those calculations is dated March 18, 2022 and, ten (10) days later, the Providers filed the instant EJR request on March 28, 2022. Thus, it is clear that these estimates were prepared in anticipation of the instant EJR request and a review of these estimates demonstrates that they relate *only* to the issue for which the Providers seek EJR (as opposed to the issue that was originally appealed and used to form the group). Specifically, each of these estimates shows the "[p]otential impact of using covered days (per CMS) with the decrease in SSI days added to Medi-Cal." For example, the estimated amount in controversy included for Orange Coast at Tab 3E of the Schedule of Providers where Orange Coast's DSH payment would increase by an estimated $37,078 due to: (1) an increase in the Medicare fraction from 13.41 percent to 13.44 percent by *removing* no pay Part A days (as relevant, from both the numerator and denominator of the Medicare fraction) so that only "covered days" remain; and (2) an increase in the number of Medi-Cal Eligible days from 938 to 953 as used in the numerator of the Medicaid fraction. Thus, these estimates clearly show either an increase or a decrease to the Medicare fraction (by removing any no-pay Part A days, as relevant from the numerator and denominator of the Medicare fraction[81]) and an

[80] The individual appeals for each of these providers included multiple issues and, rather than giving an amount in controversy for each issue, each provider relied on the issues in the aggregate to meet the minimum $10,000 amount in controversy required for an individual appeal. *See* 42 C.F.R. § 405.1839(a)(2).
[81] Whether the removal of the no-pay Part A days results in a decrease versus an increase in the Medicare fraction depends on how many of these days involve patients who are also SSI recipients since the subset of days associated

increase to the Medicaid fraction (by including in the numerator of the Medicaid fraction the subset of those removed days that pertain to dual eligibles). In contrast, the issue statement used to form the CIRP group relates *only* to the class of dual eligible days that were excluded from ***both*** the Medicare and Medicaid fractions (*i.e.*, the days at issue are only those dual eligible days excluded from the Medicare and Medicaid fractions) and, as such, the Medicare fraction would never reflect a change (increase or decrease) for purposes of calculating an estimated amount in controversy *based on the issue statement used to form the CIRP group*.[82] Based on the above findings, it is clear that the record for the *fully-formed* group does not contain any estimated amount in controversy *for the group issue for which it was formed*.

Pursuant to 42 C.F.R. § 405.1837(a)(3), the amount in controversy for a group is determined in accordance with § 405.1839, which states, in pertinent part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under §405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000.
>
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues.
>
> (A) A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in §405.1837(a)(2) of this subpart).
>
> (B) The single issue that is common to each provider may exist over different cost reporting periods.
>
> (ii) For purposes of satisfying the amount in controversy requirement, a provider may appeal multiple cost reporting periods

---

with these SSI recipients are removed not only from the denominator of the Medicare fraction but also from the numerator of the Medicare fraction.

[82] Moreover, the Board notes that the CMS policy in effect *during the time at issue in this CIRP group* was to count all no-pay Part A days in the Medicare fraction (including those associated with patients who were also Medicaid eligible). Accordingly, if an amount in controversy had been calculated for the class of days *covered by the group issue statement* (*i.e.*, those dual eligible days that were excluded from ***both*** the Medicare *and* Medicaid fractions), it would appear that the amount in controversy for this CIRP group would be close to zero (*i.e.*, below the minimum $50,000 threshold) since, under that policy, there would be no dual eligible days excluded from both the Medicare and Medicaid fractions during the years at issue. To the extent any dual eligible days were, ***in fact***, excluded from both fractions (as alleged but yet contrary to that policy), then that would be a factual issue and would presumably be similar to the systemic data match issues raised in the *Baystate* litigation. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, Adm'r Dec. (May 11, 2006); *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008).

> and different providers in the group may appeal different cost reporting periods.

In addition, § 405.1837(e)(2) makes clear that the Board may consider dismissing a group appeal hearing request for failure to meet that requirement once the group is *fully formed*.

Here, it is clear that the CIRP group is ***fully formed*** and that the Providers have failed to demonstrate that they meet the $50,000 amount in controversy requirement *for the issue covered by the group*. Rather, they have attempted to add an issue to the group and, in the documentation submitted to demonstrate the Board's jurisdiction over this group, they have alleged an amount in controversy for this added issue. As previously noted, adding issues to group appeals is prohibited by regulation. As the group is fully formed and the providers have failed to establish they meet the amount in controversy *for the issue appealed by the group*, the Board hereby dismisses the group appeal pursuant to its authority under 42 C.F.R. §§ 405.1837(e)(2) and 42 C.F.R. § 405.1868(b)(2).

Further, the facts that a group appeal may contain only one issue and that the EJR request, along with estimated amounts in controversy, were submitted on an issue other than the one for which the group appeal was established, the Board must conclude that the Providers have abandoned the original group issue. This serves as an alternate, and independent, basis for dismissal.[83]

* * * * *

In summary, the Board denies the EJR request and dismisses the CIRP group (including all the remaining participants therein, as shown on the attached Schedule of Providers). Accordingly, the Board closes this CIRP group and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

5/9/2022

X Clayton J. Nix

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

[83] This is analogous to Board Rules governing position papers which specify that "If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Board Rule 25.3 (Nov. 2021). Further Board Rule 41.2 specifies:

> The Board may dismiss a case or an issue on its own motion:
>
> - If it has a reasonable basis to believe that the issues have been fully settled or abandoned:
> - Upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868); . . . .

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nina Marsden, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Ste 1600
Los Angeles, CA 90067

RE: ***EJR Determination***
MHS 2011 Medicaid Fraction Dual Eligible CIRP Group
Case No. 15-2024GC

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 28, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal. The decision of the Board to *deny* EJR is set forth below.

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

By letter dated April 25, 2022, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group case consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On March 22, 2022, subsequent to the submission of the EJR request in this appeal, the Board notified you of the relevance of Alert 19 to the EJR request. In particular, the Board notified you of the following:

> As the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under" the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b).

In this regard, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "***only if*** . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days ***after*** finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete."[1] Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[2]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. The issuance of this determination completes the Board jurisdictional review process and the Board is concurrently issuing its determination on the EJR request as the Board is familiar with the legal issues raised in the EJR request and has previously issued similar EJR determinations for those legal issues.

Issue in Dispute

The provider used to establish this CIRP group is Orange Coast Memorial Medical Center (hereinafter "Orange Coast" or "Founding Provider"). The issue statement transferred from the Founding Provider's initial appeal request reads as follows:

> ISSUE: Dual eligible days *excluded from the Medicaid* ***and*** *SSI ratios*.
>
> BRIEF DESCRIPTION: Whether the MAC utilized the appropriate Medicaid and/or SSI ratios in the calculation of the DSH and LIP adjustments as *dual eligible days were excluded from* ***both*** *ratios*.
>
> . . . .

[1] (Emphasis added.)
[2] (Emphasis added.)

> BASIS FOR APPEAL: 42 C.F.R. § 412.106(b), 412.320 and 412.624(e)
>
> Dual eligible days are patient days associated with those patients who were ***not*** *included in the SSI denominator by CMS' design* as they were not directly billed to Medicare and did not flow through the [MEDPAR] system. ***These days*** are disallowed as "Medicare eligible" by the MAC from the Medicaid numerator. Hence, *neither the Medicaid fraction nor the Medicare fraction captured the days associated with this indigent population.*
>
> Dual eligible days were excluded from the Medicaid fraction for a variety of reasons. By way of example, some dual eligible days are associated with patients who are eligible for Medicaid by have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL) v. Blue Cross and Blue Shield Association . . . , PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held:
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. See Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Case No. 99-D4 [full citations omitted].
>
> Thus, in accordance with the Board's holding in Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days". . . .[3]

Similarly, the group issue statement included with the group appeal request for the group that the Founding Provider joined states:

> Whether the MAC utilized the appropriate Medicaid and/or SSI ratio in the calculation of the operating and capital DSH and LIP adjustments since dual eligible days were ***excluded from both ratios***.
>
> Dual eligible days are patient days associated with those patients who were *not included in the SSI denominator by CMS' design* as they were not directly billed to Medicare and did not flow through

[3] PRRB Case 15-0892, Individual Appeal Request, Issue 4 (Jan. 8, 2015) (emphasis added).

> the Medicare Provider Analysis and Review ("MEPAR") system. These days were disallowed as "Medicare eligible" by the MAC from the Medicaid numerator. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with this indigent population.
>
> Dual eligible days were excluded from the Medicaid fraction for a variety or reasons. By way of example, some dual eligible days are associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held:
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. See Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Case No. 99-D4 [full citations omitted].
>
> Thus, in accordance with the Board's holding in Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".[4]

In contrast, the EJR request for the CIRP group frames the legal question as follows:

> The Group Appeal challenges the regulation and policy of [CMS], promulgated as part of the FY 2005 IPPS Final Rule, to count exhausted or otherwise non-covered days for patients eligible for Medicare *in the Medicare/SSI fraction* and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction, as adopted and applied by CMS for purposes of calculating the Hospitals' Medicare [DSH] payments during their respective fiscal years included in the Group Appeal.[5]

The following excerpts from this EJR request shed additional light on the nature of this legal question:

- "As Section III below shows, the Hospitals are challenging the validity of CMS's regulation and policy to count exhausted or otherwise non-covered days for patients

[4] (Emphasis added.)
[5] Request for Expedited Judicial Review, 1-2 (Mar. 28, 2022) ("EJR Request").

eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction."[6]

- "Part A exhausted or noncovered days should, for dually-eligible patients, be ***included*** *in the numerator of the Medicaid fraction*, ***and excluded*** *from the Medicare/SSI fraction*, because, by definition, those days relate to patients who were not 'entitled to' Medicare Part A benefits 'for such days' when the services were provided. Part A exhausted days and noncovered days should be excluded from the Medicare/SSI fraction for the same reason."[7]

- "Accordingly, CMS's regulation and policy requiring *including* Part A exhausted and other noncovered days in the Medicare/SSI fraction, ***and*** *excluding* such days from the numerator of the Medicaid fraction for dually-eligible patients, are 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,' 5 U.S.C. §706(2)(A), 'in excess of statutory jurisdiction, authority, or limitations, or short of statutory right,' id. §706(2)(C), and/or were not promulgated in accordance with applicable notice and comment requirements under, 42 U.S.C. §1395hh and/or 5 U.S.C. §553."[8]

Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[9] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[10]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[11] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[12]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[13] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying

[6] *Id.* at 2 (emphasis added).
[7] *Id.* at 5 (emphasis added).
[8] *Id.* at 6 (emphasis added.)
[9] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[10] *Id.*
[11] *See* 42 U.S.C. § 1395ww(d)(5).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[13] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).

hospital.[14] The DPP is defined as the sum of two fractions expressed as percentages.[15] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[16]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[17]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[18]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[19]

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

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare

[14] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[15] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[16] (Emphasis added.)
[17] 42 C.F.R. § 412.106(b)(2)-(3).
[18] (Emphasis added.)
[19] 42 C.F.R. § 412.106(b)(4).

inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[20] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[21]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[22] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[23] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[24]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[25] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[26] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[27]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH

[20] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.* at 27207-27208.
[25] *Id.* at 27207-08.
[26] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[27] 68 Fed. Reg. at 27208.

calculation.[28] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [29] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[30]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[31] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[32]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[33] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently *misstated* our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[34]

****

[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[32] *Id.*
[33] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[34] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).

> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[35]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[36] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[37] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[38]

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

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that--*

[35] *Id.* at 49099 (emphasis added).
[36] *Id.*
[37] *See id.* at 49099, 49246.
[38] (Emphasis added.)

> Are associated with discharges occurring during each month; and
>
> (A) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[39]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[40]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[41] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[42]

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

---

[39] (Emphasis added.)
[40] *Id.*
[41] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).
[42] (Citations omitted and emphasis added.)
[43] 317 F. Supp. 3d 168 (D.D.C. 2018).

procedurally defective and arbitrary and capricious.[44] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[45] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[46] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[47] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

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

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

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[56] and reversed that Court's finding that the revision made by

[44] *Id.* at 172.
[45] *Id.* at 190.
[46] *Id.* at 194.
[47] *See* 2019 WL 668282.
[48] 718 F.3d 914 (2013).
[49] 657 F.3d 1 (D.C. Cir. 2011).
[50] 718 F.3d at 920.
[51] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[52] *Id.* at 1141.
[53] *Id.*
[54] *Id.* at 1162.
[55] *Id.* at 1163
[56] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).

the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[57] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[58] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[59] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[60] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[61] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[62] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[63] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

Providers' Position

Issue Outlined in the EJR Request for the CIRP Group

The Providers in the CIRP group requested EJR to challenge the inclusion of certain Part A non-covered (*e.g.*, Part A exhausted) patient days in the Medicare fraction of the DSH calculation. The Providers argue that CMS has been inconsistent with the treatment of days for Medicare inpatients who have exhausted their Part A benefits or whose days have otherwise not been paid

[57] *Id.* at 884.
[58] *Id.* at 884.
[59] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[60] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[61] *Id.* at 886.
[62] *Id.*
[63] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

(Part A exhausted and other non-covered days). They note that, while historically these days were not counted in the Medicare fraction, CMS proposed in the FY 2004 IPPS Proposed Rule to count the days for patients who were dually-eligible in the numerator of the Medicaid fraction. However, CMS did not enact this proposal. Rather, in the FY 2005 IPPS Final Rule, CMS finalized the opposite policy: Part A exhausted and non-covered days would be counted in the Medicare fraction, and these days would be excluded from dual-eligible days in the Medicaid fraction numerator. The Providers assert that this policy change resulted in those exhausted non-covered days associated with dually eligible patients being excluded from the Medicaid fraction's numerator and only potentially being included in the Medicare fraction's numerator.[64]

The Providers contend that the policy adopted in the FY 2005 IPPS Final Rule and the associated regulatory changes were substantively and/or procedurally invalid. They claim that these no-pay Part A days should be included in the numerator of the Medicaid fraction (for the subset of those days associated with dually-eligible patients) and excluded in full from the Medicare fraction (both the numerator and denominator) because these days relate to patients who were not "entitled to" Part A benefits "for such days" when the services were provided. They state that CMS' policy deserves no deference. They contend that CMS misstated both its current and proposed policies in its FY 2004 and 2005 rulemaking, failed to provide adequate notice and opportunity for comment, and has interpreted "entitled to benefits under [Medicare Part A]" for purposes of the DSH fractions in a manner inconsistent with the statute and precedent. They note that the Ninth Circuit's decision in *Empire Health Foundation v. Azar* vacated the regulation at issue.[65] The Providers maintain EJR is appropriate because the regulation was held to be invalid and is being reviewed by the Supreme Court, and because the Board lacks the authority to review the validity of a regulation.[66]

Issue Appealed by the CIRP Group

As previously noted, this CIRP group was created after the Founding Provider transferred its Dual Eligible days issue from an individual appeal. In the individual appeal, the stated issue is simply stated as "Dual eligible days excluded from the Medicaid ***and*** SSI Ratios."[67] The "Basis for Appeal," thus, appears to describe CMS' pre-October 1, 2004 policy (*i.e.*, the policy in effect prior to the FY 2005 IPPS Final Rule) to exclude no-pay Part A days (including days associated with patients who were dual eligibles) from ***both*** the Medicare fraction and the Medicaid fraction.[68] Indeed, both the Founding Provider's transferred issue statement and the group issue statement state that the issue of the group pertains to those days that "were not included in the SSI [*i.e.*, Medicare] denominator by design" (*i.e.*, no pay dual eligible days) and were "disallowed . . . from the Medicaid numerator. Hence, ***neither*** *the Medicaid fraction* ***nor*** *the Medicare fraction captured the days associated with this indigent population.*"[69] In support of its position, both the Founding Provider and the group issue statement cite to *Edgewater Med.*

[64] EJR Request at 4-5.
[65] *Id.* at 6 (citing to 958 F.3d 873 (9th Cir. 2020).
[66] *Id.* at 5-6.
[67] (Emphasis added.)
[68] *See* CMS Ruling 1498-R2 at 3 (Apr. 22, 2015); CMS Ruling 1498-R at 7-8 (Apr. 28, 2010).
[69] (Emphasis added).

Ctr. v. Blue Cross and Blue Shield Ass'n,[70] a Board decision issued in 2000 which involved a provider's 1990 fiscal year and clearly predates the dual eligible days policy enacted in FY 2005 IPPS Final Rule, which is the subject of the instant EJR Request.

Decision of the Board

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

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [71]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[72]

For an issue to be added to an existing appeal, the request for addition must comply with the same requirements for requesting a Board hearing in an initial appeal.[73] When the underlying individual appeal was filed, the Board Rules (Mar. 1, 2013) required Providers to, for each issue under appeal, provide the basis for dissatisfaction with its final determination. With regard to identifying the issue, Providers were required to provide an issue statement that described the adjustment, ***why the adjustment was incorrect***, and how the payment should be determined differently.[74] Similarly, the regulation at 42 C.F.R. § 405.1835(b) (2014) stated:

> (b) *Contents of request for a Board hearing*. The provider's request for *a Board hearing* must be submitted in writing to the Board, and the request **must include the elements** described in

[70] PRRB Dec. 2000-D44 (Apr. 7, 2000).
[71] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[72] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[73] 42 C.F.R. § 405.1835(e).
[74] PRRB Rule 7 (Mar. 1, 2013) (emphasis added). *See also* Board Rule 8 (stating "Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7." (emphasis added)).

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

Failure to meet these requirements permits the Board to dismiss the issue with prejudice or take any other remedial action it considers appropriate.[75] A request to add an additional issue is timely made if received by the Board no later than 240 days after the date of a final determination.[76]

The requirements for establishing a group appeal are similar. In this regard, 42 C.F.R. § 405.1837(c) (2014) addresses the content of a group appeal request:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.

[75] 42 C.F.R. § 405.1835(b).
[76] 42 C.F.R. § 405.1835(c)(3) (2013).

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

The Board finds that the Providers in this CIRP group have appealed only those "dual eligible days" that it alleges were excluded from ***both*** the Medicare fraction ***and*** the Medicare fraction (as reflected in the CMS policy predating the FY 2005 IPPS Final Rule).[77] The issue statement used to form the group do not refer to no-pay Part A days of which exhausted days or Medicare

[77] The issue statement associated with the individual appeals that established the group appeal clearly defines the term "dual eligible days" as used therein as those days that "were not included in the SSI [*i.e.*, Medicare] denominator by CMS' design" where "***[t]hese*** *days* were [also] disallowed as 'Medicare eligible' by the MAC from the Medicaid numerator." (Emphasis added.) Similarly, the only authority cited by the Providers in their issue statement is the Board's 2000 decision in *Edgewater* which, as discussed *supra*, clearly involved and applied the pre-October 1, 2004 policy.

secondary payor ("MSP") days are just a subset.[78] In this regard, the Board notes that a reference to "dual eligible days" for a hospital's fiscal year is clearly different than no-pay Part A days where the underlying patients associated with those days across a fiscal year largely were not Medicaid eligible and only a subset of those patients were Medicaid eligible.

In contrast, the EJR request concerns the FY 2005 IPPS Final Rule and challenges CMS' policy set forth therein to count *all* no-pay Part A days in the Medicare fraction effective for discharges on or after October 1, 2004 and seeks to include the subset of those days for which the underlying patients were also Medicaid eligible in the numerator of the Medicaid fraction. Any challenge to that policy would necessarily be a separate and distinct issue from the one appealed in the issue statement for this CIRP group. As such, the Board finds that the Providers' EJR request attempts to add issues to this CIRP group, namely: (1) the exclusion of all no-pay part A days from the Medicare fraction; and (2) the inclusion of the ***subset*** of those days, for which the underlying patients were also Medicaid eligible (*i.e.*, were dually eligible), in the numerator of the Medicaid fraction. However, 42 C.F.R. § 405.1837(f)(1) makes clear that issues may *not* be added to a group appeal after the group hearing request is filed. As such, the Board finds that it lacks jurisdiction in these appeals over the ***specific*** issue sought in its EJR Request because it was not included in the original appeals in violation of the content-specificity requirements in 42 C.F.R. §§ 405.1835(b) and 405.1837(c), and, since jurisdiction is a prerequisite to granting EJR, the Board hereby ***denies*** the EJR Request for Case No. 15-2024GC.

Finally, the Board notes that one requirement for Board jurisdiction over a group is that the group have, in the aggregate, at least $50,000 or more in controversy as specified in 42 C.F.R. § 405.1840(a). Here, each of the Providers participating in the instant CIRP group did not include a specific amount in controversy for the issue that they transferred to the instant CIRP group.[79] Thus, for purpose of demonstrating that they met the minimum $50,000 amount in controversy for purposes of forming a group, the Providers included in the final Schedule of Providers a calculation of the estimated amount in controversy for each Provider. Each of those calculations is dated March 18, 2022 and, ten (10) days later, the Providers filed the instant EJR request on March 28, 2022. Thus, it is clear that these estimates were prepared in anticipation of the instant EJR request and a review of these estimates demonstrates that they relate *only* to the issue for which the Providers seek EJR (as opposed to the issue that was originally appealed and used to form the group). Specifically, each of these estimates shows the "[p]otential impact of using covered days (per CMS) with the decrease in SSI days added to Medi-Cal." For example, the estimated amount in controversy included for Orange Coast at Tab 3E of the Schedule of Providers where Orange Coast's DSH payment would increase by an estimated $45,048 due to: (1) an increase in the Medicare fraction from 13.92 percent to 14.10 percent by *removing* no pay

[78] The Board looked to both the group issue statement *and* the issue statement transferred in by the Founding Provider since the group cannot be any more than the issue that the Founding Provider had appealed and was transferring into the group. In other words, the Founding Provider can only transfer what it had already established in its individual appeal (anything more would be have to be properly added to the individual appeal prior to transfer) and the CIRP group only exists by virtue of the Founding Provider which means it can be no more than what the Founding Provider transfers.

[79] The individual appeals for each of these providers included multiple issues and, rather than giving an amount in controversy for each issue, each provider relied on the issues in the aggregate to meet the minimum $10,000 amount in controversy required for an individual appeal. *See* 42 C.F.R. § 405.1839(a)(2).

Part A days (as relevant, from both the numerator and denominator of the Medicare fraction) so that only "covered days" remain; and (2) an increase in the number of Medi-Cal FSS days from 1,898 to 1,951 as used in the numerator of the Medicaid fraction. Thus, these estimates clearly either an increase or a decrease to the Medicare fraction (by removing any no-pay Part A days, as relevant from the numerator and denominator of the Medicare fraction[80]) and an increase to the Medicaid fraction (by including in the numerator of the Medicaid fraction the subset of those removed days that pertain to dual eligibles). In contrast, the issue statement used to form the CIRP group relates *only* to the class of dual eligible days that were excluded from ***both*** the Medicare and Medicaid fractions (*i.e.*, the days at issue are only those dual eligible days excluded from the Medicare and Medicaid fractions) and, as such, the Medicare fraction would never reflect a change (increase or decrease) for purposes of calculating an estimated amount in controversy *based on the issue statement used to form the CIRP group*.[81] Based on the above findings, it is clear that the record for the *fully-formed* group does not contain any estimated amount in controversy *for the group issue for which it was formed*.

Pursuant to 42 C.F.R. § 405.1837(a)(3), the amount in controversy for a group is determined in accordance with § 405.1839, which states, in pertinent part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under §405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000.
>
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues.
>
> (A) A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in §405.1837(a)(2) of this subpart).

[80] Whether the removal of the no-pay Part A days results in a decrease versus an increase in the Medicare fraction depends on how many of these days involve patients who are also SSI recipients since the subset of days associated with these SSI recipients are removed not only from the denominator of the Medicare fraction but also from the numerator of the Medicare fraction.

[81] Moreover, the Board notes that the CMS policy in effect *during the time at issue in this CIRP group* was to count all no-pay Part A days in the Medicare fraction (including those associated with patients who were also Medicaid eligible). Accordingly, if an amount in controversy had been calculated for the class of days *covered by the group issue statement* (*i.e.*, those dual eligible days that were excluded from ***both*** the Medicare *and* Medicaid fractions), it would appear that the amount in controversy for this CIRP group would be close to zero (*i.e.*, below the minimum $50,000 threshold) since, under that policy, there would be no dual eligible days excluded from both the Medicare and Medicaid fractions during the years at issue. To the extent any dual eligible days were, ***in fact***, excluded from both fractions (as alleged but yet contrary to that policy), then that would be a factual issue and would presumably be similar to the systemic data match issues raised in the *Baystate* litigation. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, Adm'r Dec. (May 11, 2006); *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008).

> (B) The single issue that is common to each provider may exist over different cost reporting periods.
>
> (ii) For purposes of satisfying the amount in controversy requirement, a provider may appeal multiple cost reporting periods and different providers in the group may appeal different cost reporting periods.

In addition, § 405.1837(e)(2) makes clear that the Board may consider dismissing a group appeal hearing request for failure to meet that requirement once the group is *fully formed*.

Here, it is clear that the CIRP group is ***fully formed*** and that the Providers have failed to demonstrate that they meet the $50,000 amount in controversy requirement *for the issue covered by the group*. Rather, they have attempted to add an issue to the group and, in the documentation submitted to demonstrate the Board's jurisdiction over this group, they have alleged an amount in controversy for this added issue. As previously noted, adding issues to group appeals is prohibited by regulation. As the group is fully formed and the providers have failed to establish they meet the amount in controversy *for the issue appealed by the group*, the Board hereby dismisses the group appeal pursuant to its authority under 42 C.F.R. §§ 405.1837(e)(2) and 42 C.F.R. § 405.1868(b)(2).

Further, the facts that a group appeal may contain only one issue and that the EJR request, along with estimated amounts in controversy, were submitted on an issue other than the one for which the group appeal was established, the Board must conclude that the Providers have abandoned the original group issue. This serves as an alternate, and independent, basis for dismissal.[82]

* * * * *

In summary, the Board denies the EJR request and dismisses the CIRP group (including all the remaining participants therein, as shown on the attached Schedule of Providers). Accordingly, the Board closes this CIRP group and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

---

[82] This is analogous to Board Rules governing position papers which specify that "If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Board Rule 25.3 (Nov. 2021). Further Board Rule 41.2 specifies:

> The Board may dismiss a case or an issue on its own motion:
>
> - If it has a reasonable basis to believe that the issues have been fully settled or abandoned:
> - Upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868); . . . .

Board Members Participating:

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

FOR THE BOARD:

5/9/2022

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nina Marsden, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Ste 1600
Los Angeles, CA 90067

RE: ***EJR Determination***
MHS 2012 Medicaid Fraction Dual Eligible CIRP Group
Case No. 15-2066GC

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 28, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal. The decision of the Board to *deny* EJR is set forth below.

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

By letter dated April 25, 2022, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group case consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On March 22, 2022, subsequent to the submission of the EJR request in this appeal, the Board notified you of the relevance of Alert 19 to the EJR request. In particular, the Board notified you of the following:

> As the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under" the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b).

In this regard, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "***only if*** . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days ***after*** finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete."[1] Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[2]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. The issuance of this determination completes the Board jurisdictional review process and the Board is concurrently issuing its determination on the EJR request as the Board is familiar with the legal issues raised in the EJR request and has previously issued similar EJR determinations for those legal issues.

Issue in Dispute

The provider used to establish this CIRP group is Orange Coast Memorial Medical Center (hereinafter "Orange Coast" or "Founding Provider"). The issue statement transferred from the Founding Provider's initial appeal request reads as follows:

> ISSUE: Dual eligible days *excluded from the Medicaid* ***and*** *SSI ratios*.
>
> BRIEF DESCRIPTION: Whether the MAC utilized the appropriate Medicaid and/or SSI ratios in the calculation of the DSH and LIP adjustments as *dual eligible days were excluded from* ***both*** *ratios*.
>
> . . . .

[1] (Emphasis added.)
[2] (Emphasis added.)

> BASIS FOR APPEAL: 42 C.F.R. § 412.106(b), 412.320 and 412.624(e)
>
> Dual eligible days are patient days associated with those patients who were ***not*** *included in the SSI denominator by CMS' design* as they were not directly billed to Medicare and did not flow through the [MEDPAR] system. ***These days*** are disallowed as "Medicare eligible" by the MAC from the Medicaid numerator. Hence, *neither the Medicaid fraction nor the Medicare fraction captured the days associated with this indigent population.*
>
> Dual eligible days were excluded from the Medicaid fraction for a variety of reasons. By way of example, some dual eligible days are associated with patients who are eligible for Medicaid by have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL) v. Blue Cross and Blue Shield Association . . . , PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held:
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. See Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Case No. 99-D4 [full citations omitted].
>
> Thus, in accordance with the Board's holding in Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days". . . .[3]

Similarly, the group issue statement included with the group appeal request for the group that the Founding Provider joined states:

> Whether the MAC utilized the appropriate Medicaid and/or SSI ratio in the calculation of the operating and capital DSH and LIP adjustments since dual eligible days were ***excluded from both ratios***.
>
> Dual eligible days are patient days associated with those patients who were *not included in the SSI denominator by CMS' design* as they were not directly billed to Medicare and did not flow through

[3] PRRB Case 15-0443, Individual Appeal Request, Issue 5 (Nov. 17, 2014) (emphasis added).

> the Medicare Provider Analysis and Review ("MEPAR") system. These days were disallowed as "Medicare eligible" by the MAC from the Medicaid numerator. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with this indigent population.
>
> Dual eligible days were excluded from the Medicaid fraction for a variety or reasons. By way of example, some dual eligible days are associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held:
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. See Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Case No. 99-D4 [full citations omitted].
>
> Thus, in accordance with the Board's holding in Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".[4]

In contrast, the EJR request for the CIRP group frames the legal question as follows:

> The Group Appeal challenges the regulation and policy of [CMS], promulgated as part of the FY 2005 IPPS Final Rule, to count exhausted or otherwise non-covered days for patients eligible for Medicare *in the Medicare/SSI fraction* and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction, as adopted and applied by CMS for purposes of calculating the Hospitals' Medicare [DSH] payments during their respective fiscal years included in the Group Appeal.[5]

The following excerpts from this EJR request shed additional light on the nature of this legal question:

- "As Section III below shows, the Hospitals are challenging the validity of CMS's regulation and policy to count exhausted or otherwise non-covered days for patients

[4] (Emphasis added.)
[5] Request for Expedited Judicial Review, 1-2 (Mar. 28, 2022) ("EJR Request").

eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction."[6]

- "Part A exhausted or noncovered days should, for dually-eligible patients, be ***included*** *in the numerator of the Medicaid fraction*, ***and excluded*** *from the Medicare/SSI fraction*, because, by definition, those days relate to patients who were not 'entitled to' Medicare Part A benefits 'for such days' when the services were provided. Part A exhausted days and noncovered days should be excluded from the Medicare/SSI fraction for the same reason."[7]

- "Accordingly, CMS's regulation and policy requiring *including* Part A exhausted and other noncovered days in the Medicare/SSI fraction, ***and*** *excluding* such days from the numerator of the Medicaid fraction for dually-eligible patients, are 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,' 5 U.S.C. §706(2)(A), 'in excess of statutory jurisdiction, authority, or limitations, or short of statutory right,' id. §706(2)(C), and/or were not promulgated in accordance with applicable notice and comment requirements under, 42 U.S.C. §1395hh and/or 5 U.S.C. §553."[8]

Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[9] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[10]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[11] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[12]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[13] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying

[6] *Id.* at 2 (emphasis added).
[7] *Id.* at 5 (emphasis added).
[8] *Id.* at 6 (emphasis added.)
[9] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[10] *Id.*
[11] *See* 42 U.S.C. § 1395ww(d)(5).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[13] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).

hospital.[14] The DPP is defined as the sum of two fractions expressed as percentages.[15] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[16]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[17]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[18]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[19]

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

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare

[14] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[15] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[16] (Emphasis added.)
[17] 42 C.F.R. § 412.106(b)(2)-(3).
[18] (Emphasis added.)
[19] 42 C.F.R. § 412.106(b)(4).

inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[20] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[21]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[22] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[23] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[24]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[25] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[26] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[27]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH

[20] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.* at 27207-27208.
[25] *Id.* at 27207-08.
[26] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[27] 68 Fed. Reg. at 27208.

calculation.[28] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [29] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[30]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[31] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[32]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[33] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently *misstated* our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[34]

****

[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[32] *Id.*
[33] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[34] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).

> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[35]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[36] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[37] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[38]

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

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that--*

[35] *Id.* at 49099 (emphasis added).
[36] *Id.*
[37] *See id.* at 49099, 49246.
[38] (Emphasis added.)

> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[39]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[40]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[41] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[42]

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

---

[39] (Emphasis added.)
[40] *Id.*
[41] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).
[42] (Citations omitted and emphasis added.)
[43] 317 F. Supp. 3d 168 (D.D.C. 2018).

procedurally defective and arbitrary and capricious.[44] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[45] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[46] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[47] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

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

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

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[56] and reversed that Court's finding that the revision made by

---

[44] *Id.* at 172.
[45] *Id.* at 190.
[46] *Id.* at 194.
[47] *See* 2019 WL 668282.
[48] 718 F.3d 914 (2013).
[49] 657 F.3d 1 (D.C. Cir. 2011).
[50] 718 F.3d at 920.
[51] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[52] *Id.* at 1141.
[53] *Id.*
[54] *Id.* at 1162.
[55] *Id.* at 1163
[56] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).

the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[57] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[58] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[59] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[60] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[61] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[62] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[63] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

Providers' Position

Issue Outlined in the EJR Request for the CIRP Group

The Providers in the CIRP group requested EJR to challenge the inclusion of certain Part A non-covered (*e.g.*, Part A exhausted) patient days in the Medicare fraction of the DSH calculation. The Providers argue that CMS has been inconsistent with the treatment of days for Medicare inpatients who have exhausted their Part A benefits or whose days have otherwise not been paid

[57] *Id.* at 884.
[58] *Id.* at 884.
[59] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[60] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[61] *Id.* at 886.
[62] *Id.*
[63] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

(Part A exhausted and other non-covered days). They note that, while historically these days were not counted in the Medicare fraction, CMS proposed in the FY 2004 IPPS Proposed Rule to count the days for patients who were dually-eligible in the numerator of the Medicaid fraction. However, CMS did not enact this proposal. Rather, in the FY 2005 IPPS Final Rule, CMS finalized the opposite policy: Part A exhausted and non-covered days would be counted in the Medicare fraction, and these days would be excluded from dual-eligible days in the Medicaid fraction numerator. The Providers assert that this policy change resulted in those exhausted non-covered days associated with dually eligible patients being excluded from the Medicaid fraction's numerator and only potentially being included in the Medicare fraction's numerator.[64]

The Providers contend that the policy adopted in the FY 2005 IPPS Final Rule and the associated regulatory changes were substantively and/or procedurally invalid. They claim that these no-pay Part A days should be included in the numerator of the Medicaid fraction (for the subset of those days associated with dually-eligible patients) and excluded in full from the Medicare fraction (both the numerator and denominator) because these days relate to patients who were not "entitled to" Part A benefits "for such days" when the services were provided. They state that CMS' policy deserves no deference. They contend that CMS misstated both its current and proposed policies in its FY 2004 and 2005 rulemaking, failed to provide adequate notice and opportunity for comment, and has interpreted "entitled to benefits under [Medicare Part A]" for purposes of the DSH fractions in a manner inconsistent with the statute and precedent. They note that the Ninth Circuit's decision in *Empire Health Foundation v. Azar* vacated the regulation at issue.[65] The Providers maintain EJR is appropriate because the regulation was held to be invalid and is being reviewed by the Supreme Court, and because the Board lacks the authority to review the validity of a regulation.[66]

Issue Appealed by the CIRP Group

As previously noted, this CIRP group was created after the Founding Provider transferred its Dual Eligible days issue from an individual appeal. In the individual appeal, the stated issue is simply stated as "Dual eligible days excluded from the Medicaid ***and*** SSI Ratios."[67] The "Basis for Appeal," thus, appears to describe CMS' pre-October 1, 2004 policy (*i.e.*, the policy in effect prior to the FY 2005 IPPS Final Rule) to exclude no-pay Part A days (including days associated with patients who were dual eligibles) from ***both*** the Medicare fraction and the Medicaid fraction.[68] Indeed, both the Founding Provider's transferred issue statement and the group appealed issue statement state that the issue of the group pertains to those days that "were not included in the SSI [*i.e.*, Medicare] denominator by design" (*i.e.*, no pay dual eligible days) and were "disallowed . . . from the Medicaid numerator. Hence, ***neither*** *the Medicaid fraction* ***nor*** *the Medicare fraction captured the days associated with this indigent population*."[69] In support of its position, both the Founding Provider and the group issue statement cite to *Edgewater Med.*

[64] EJR Request at 4-5.
[65] *Id.* at 6 (citing to 958 F.3d 873 (9th Cir. 2020).
[66] *Id.* at 5-6.
[67] (Emphasis added.)
[68] *See* CMS Ruling 1498-R2 at 3 (Apr. 22, 2015); CMS Ruling 1498-R at 7-8 (Apr. 28, 2010).
[69] (Emphasis added).

Ctr. v. Blue Cross and Blue Shield Ass'n,[70] a Board decision issued in 2000 which involved a provider's 1990 fiscal year and clearly predates the dual eligible days policy enacted in FY 2005 IPPS Final Rule, which is the subject of the instant EJR Request.

Decision of the Board

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

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [71]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[72]

For an issue to be added to an existing appeal, the request for addition must comply with the same requirements for requesting a Board hearing in an initial appeal.[73] When the underlying individual appeal was filed, the Board Rules (Mar. 1, 2013) required Providers to, for each issue under appeal, provide the basis for dissatisfaction with its final determination. With regard to identifying the issue, Providers were required to provide an issue statement that described the adjustment, ***why the adjustment was incorrect***, and how the payment should be determined differently.[74] Similarly, the regulation at 42 C.F.R. § 405.1835(b) (2014) stated:

> (b) *Contents of request for a Board hearing*. The provider's request for *a Board hearing* must be submitted in writing to the Board, and the request **must include the elements** described in

[70] PRRB Dec. 2000-D44 (Apr. 7, 2000).
[71] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[72] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[73] 42 C.F.R. § 405.1835(e).
[74] PRRB Rule 7 (Mar. 1, 2013) (emphasis added). *See also* Board Rule 8 (stating "Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7." (emphasis added)).

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

Failure to meet these requirements permits the Board to dismiss the issue with prejudice or take any other remedial action it considers appropriate.[75] A request to add an additional issue is timely made if received by the Board no later than 240 days after the date of a final determination.[76]

The requirements for establishing a group appeal are similar. In this regard, 42 C.F.R. § 405.1837(c) (2014) addresses the content of a group appeal request:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.

[75] 42 C.F.R. § 405.1835(b).
[76] 42 C.F.R. § 405.1835(c)(3) (2013).

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

The Board finds that the Providers in this CIRP group have appealed only those "dual eligible days" that it alleges were excluded from ***both*** the Medicare fraction ***and*** the Medicare fraction (as reflected in the CMS policy predating the FY 2005 IPPS Final Rule).[77] The issue statement used to form the group do not refer to no-pay Part A days of which exhausted days or Medicare

[77] The issue statement associated with the individual appeals that established the group appeal clearly defines the term "dual eligible days" as used therein as those days that "were not included in the SSI [*i.e.*, Medicare] denominator by CMS' design" where "***[t]hese*** *days* were [also] disallowed as 'Medicare eligible' by the MAC from the Medicaid numerator." (Emphasis added.) Similarly, the only authority cited by the Providers in their issue statement is the Board's 2000 decision in *Edgewater* which, as discussed *supra*, clearly involved and applied the pre-October 1, 2004 policy.

secondary payor ("MSP") days are just a subset.[78] In this regard, the Board notes that a reference to "dual eligible days" for a hospital's fiscal year is clearly different than no-pay Part A days where the underlying patients associated with those days across a fiscal year largely were not Medicaid eligible and only a subset of those patients were Medicaid eligible.

In contrast, the EJR request concerns the FY 2005 IPPS Final Rule and challenges CMS' policy set forth therein to count *all* no-pay Part A days in the Medicare fraction effective for discharges on or after October 1, 2004 and seeks to include the subset of those days for which the underlying patients were also Medicaid eligible in the numerator of the Medicaid fraction. Any challenge to that policy would necessarily be a separate and distinct issue from the one appealed in the issue statement for this CIRP group. As such, the Board finds that the Providers' EJR request attempts to add issues to this CIRP group, namely: (1) the exclusion of all no-pay part A days from the Medicare fraction; and (2) the inclusion of the ***subset*** of those days, for which the underlying patients were also Medicaid eligible (*i.e.*, were dually eligible), in the numerator of the Medicaid fraction. However, 42 C.F.R. § 405.1837(f)(1) makes clear that issues may *not* be added to a group appeal after the group hearing request is filed. As such, the Board finds that it lacks jurisdiction in these appeals over the ***specific*** issue sought in its EJR Request because it was not included in the original appeals in violation of the content-specificity requirements in 42 C.F.R. §§ 405.1835(b) and 405.1837(c), and, since jurisdiction is a prerequisite to granting EJR, the Board hereby ***denies*** the EJR Request for Case No. 15-2066GC.

Finally, the Board notes that one requirement for Board jurisdiction over a group is that the group have, in the aggregate, at least $50,000 or more in controversy as specified in 42 C.F.R. § 405.1840(a). Here, each of the Providers participating in the instant CIRP group did not include a specific amount in controversy for the issue that they transferred to the instant CIRP group.[79] Thus, for purpose of demonstrating that they met the minimum $50,000 amount in controversy for purposes of forming a group, the Providers included in the final Schedule of Providers a calculation of the estimated amount in controversy for each Provider. Each of those calculations is dated March 18, 2022 and, ten (10) days later, the Providers filed the instant EJR request on March 28, 2022. Thus, it is clear that these estimates were prepared in anticipation of the instant EJR request and a review of these estimates demonstrates that they relate *only* to the issue for which the Providers seek EJR (as opposed to the issue that was originally appealed and used to form the group). Specifically, each of these estimates shows the "[p]otential impact of using covered days (per CMS) with the decrease in SSI days added to Medi-Cal." For example, the estimated amount in controversy included for Orange Coast at Tab 3E of the Schedule of Providers where Orange Coast's DSH payment would increase by an estimated $45,048 due to: (1) an increase in the Medicare fraction from 16.97 percent to 17.21 percent by *removing* no pay

[78] The Board looked to both the group issue statement *and* the issue statement transferred in by the Founding Provider since the group cannot be any more than the issue that the Founding Provider had appealed and was transferring into the group. In other words, the Founding Provider can only transfer what it had already established in its individual appeal (anything more would be have to be properly added to the individual appeal prior to transfer) and the CIRP group only exists by virtue of the Founding Provider which means it can be no more than what the Founding Provider transfers.

[79] The individual appeals for each of these providers included multiple issues and, rather than giving an amount in controversy for each issue, each provider relied on the issues in the aggregate to meet the minimum $10,000 amount in controversy required for an individual appeal. *See* 42 C.F.R. § 405.1839(a)(2).

Part A days (as relevant, from both the numerator and denominator of the Medicare fraction) so that only "covered days" remain; and (2) an increase in the number of Medi-Cal Eligible days from 2,504 to 2,588 as used in the numerator of the Medicaid fraction. Thus, these estimates clearly show either an increase or decrease to the Medicare fraction (by removing no-pay Part A days, as relevant, from the numerator and denominator of the Medicare fraction[80]) and an increase to the Medicaid fraction (by including in the numerator of the Medicaid fraction the subset of those removed days that pertain to dual eligibles).[81] In contrast, the issue statement used to form the CIRP group relates *only* to the class of dual eligible days that were excluded from ***both*** the Medicare and Medicaid fractions (*i.e.*, the days at issue are only those dual eligible days excluded from the Medicare and Medicaid fractions) and, as such, the Medicare fraction would never reflect a change (increase or decrease) for purposes of calculating an estimated amount in controversy *based on the issue statement used to form the CIRP group*. Based on the above findings, it is clear that the record for the *fully-formed* group does not contain any estimated amount in controversy *for the group issue for which it was formed*.

Pursuant to 42 C.F.R. § 405.1837(a)(3), the amount in controversy for a group is determined in accordance with § 405.1839, which states, in pertinent part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under §405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000.
>
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues.
>
> (A) A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in §405.1837(a)(2) of this subpart).

[80] Whether the removal of the no-pay Part A days results in a decrease versus an increase in the Medicare fraction depends on how many of these days involve patients who are also SSI recipients since the subset of days associated with these SSI recipients are removed not only from the denominator of the Medicare fraction but also from the numerator of the Medicare fraction.

[81] Moreover, the Board notes that the CMS policy in effect *during the time at issue in this CIRP group* was to count all no-pay Part A days in the Medicare fraction (including those associated with patients who were also Medicaid eligible). Accordingly, if an amount in controversy had been calculated for the class of days *covered by the group issue statement* (*i.e.*, those dual eligible days that were excluded from ***both*** the Medicare *and* Medicaid fractions), it would appear that the amount in controversy for this CIRP group would be close to zero (*i.e.*, below the minimum $50,000 threshold) since, under that policy, there would be no dual eligible days excluded from both the Medicare and Medicaid fractions during the years at issue. To the extent any dual eligible days were, ***in fact***, excluded from both fractions (as alleged but yet contrary to that policy), then that would be a factual issue and would presumably be similar to the systemic data match issues raised in the *Baystate* litigation. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, Adm'r Dec. (May 11, 2006); *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008).

> (B) The single issue that is common to each provider may exist over different cost reporting periods.
>
> (ii) For purposes of satisfying the amount in controversy requirement, a provider may appeal multiple cost reporting periods and different providers in the group may appeal different cost reporting periods.

In addition, § 405.1837(e)(2) makes clear that the Board may consider dismissing a group appeal hearing request for failure to meet that requirement once the group is *fully formed*.

Here, it is clear that the CIRP group is ***fully formed*** and that the Providers have failed to demonstrate that they meet the $50,000 amount in controversy requirement *for the issue covered by the group*. Rather, they have attempted to add an issue to the group and, in the documentation submitted to demonstrate the Board's jurisdiction over this group, they have alleged an amount in controversy for this added issue. As previously noted, adding issues to group appeals is prohibited by regulation. As the group is fully formed and the providers have failed to establish they meet the amount in controversy *for the issue appealed by the group*, the Board hereby dismisses the group appeal pursuant to its authority under 42 C.F.R. §§ 405.1837(e)(2) and 42 C.F.R. § 405.1868(b)(2).

Further, the facts that a group appeal may contain only one issue and that the EJR request, along with estimated amounts in controversy, were submitted on an issue other than the one for which the group appeal was established, the Board must conclude that the Providers have abandoned the original group issue. This serves as an alternate, and independent, basis for dismissal.[82]

* * * * *

In summary, the Board denies the EJR request and dismisses the CIRP group (including all the remaining participants therein, as shown on the attached Schedule of Providers). Accordingly, the Board closes this CIRP group and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

---

[82] This is analogous to Board Rules governing position papers which specify that "If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Board Rule 25.3 (Nov. 2021). Further Board Rule 41.2 specifies:

> The Board may dismiss a case or an issue on its own motion:
>
> - If it has a reasonable basis to believe that the issues have been fully settled or abandoned:
> - Upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868); . . . .

Board Members Participating:

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

FOR THE BOARD:

5/9/2022

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nina Marsden, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Ste 1600
Los Angeles, CA 90067

RE: ***EJR Determination***
MHS 2013 Dual Eligible CIRP Group
Case No. 16-0982GC

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 28, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal. The decision of the Board to *deny* EJR is set forth below.

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

By letter dated April 25, 2022, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group case consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On March 22, 2022, subsequent to the submission of the EJR request in this appeal, the Board notified you of the relevance of Alert 19 to the EJR request. In particular, the Board notified you of the following:

> As the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under" the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b).

In this regard, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "***only if*** . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days ***after*** finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete."[1] Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[2]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. The issuance of this determination completes the Board jurisdictional review process and the Board is concurrently issuing its determination on the EJR request as the Board is familiar with the legal issues raised in the EJR request and has previously issued similar EJR determinations for those legal issues.

Issue in Dispute

The provider used to establish this CIRP group is Orange Coast Memorial Medical Center (hereinafter "Orange Coast" or "Founding Provider"). The issue statement transferred from the Founding Provider's initial appeal request reads as follows:

> ISSUE: Dual eligible days *excluded from the Medicaid* ***and*** *SSI ratios*.
>
> BRIEF DESCRIPTION: Whether the MAC utilized the appropriate Medicaid and/or SSI ratios in the calculation of the DSH and LIP adjustments as *dual eligible days were excluded from* ***both*** *ratios*.
>
> . . . .

[1] (Emphasis added.)
[2] (Emphasis added.)

> BASIS FOR APPEAL: 42 C.F.R. § 412.106(b), 412.320 and 412.624(e)
>
> Dual eligible days are patient days associated with those patients who were ***not*** *included in the SSI denominator by CMS' design* as they were not directly billed to Medicare and did not flow through the [MEDPAR] system. ***These days*** are disallowed as "Medicare eligible" by the MAC from the Medicaid numerator. Hence, *neither the Medicaid fraction nor the Medicare fraction captured the days associated with this indigent population.*
>
> Dual eligible days were excluded from the Medicaid fraction for a variety of reasons. By way of example, some dual eligible days are associated with patients who are eligible for Medicaid by have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL) v. Blue Cross and Blue Shield Association . . . , PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held:
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. See Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Case No. 99-D4 [full citation omitted].
>
> Thus, in accordance with the Board's holding in Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days". . . .[3]

Similarly, the group issue statement included with the group appeal request for the group that the Founding Provider joined states:

> Whether the MAC utilized the appropriate Medicaid and/or SSI ratio in the calculation of the operating and capital DSH and LIP adjustments since dual eligible days were ***excluded from both ratios***.
>
> Dual eligible days are patient days associated with those patients who were *not included in the SSI denominator by CMS' design* as they were not directly billed to Medicare and did not flow through

[3] PRRB Case 16-1382, Individual Appeal Request, Issue 4 (Apr. 5, 2016) (emphasis added).

> the Medicare Provider Analysis and Review ("MEPAR") system. These days were disallowed as "Medicare eligible" by the MAC from the Medicaid numerator. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with this indigent population.
>
> Dual eligible days were excluded from the Medicaid fraction for a variety or reasons. By way of example, some dual eligible days are associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held:
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. See Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Case No. 99-D4 [full citations omitted].
>
> Thus, in accordance with the Board's holding in Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".[4]

In contrast, the EJR request for the CIRP group frames the legal question as follows:

> The Group Appeal challenges the regulation and policy of [CMS], promulgated as part of the FY 2005 IPPS Final Rule, to count exhausted or otherwise non-covered days for patients eligible for Medicare *in the Medicare/SSI fraction* and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction, as adopted and applied by CMS for purposes of calculating the Hospitals' Medicare [DSH] payments during their respective fiscal years included in the Group Appeal.[5]

The following excerpts from this EJR request shed additional light on the nature of this legal question:

- "As Section III below shows, the Hospitals are challenging the validity of CMS's regulation and policy to count exhausted or otherwise non-covered days for patients

[4] (Emphasis added.)
[5] Request for Expedited Judicial Review, 1-2 (Mar. 28, 2022) ("EJR Request").

eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction."[6]

- "Part A exhausted or noncovered days should, for dually-eligible patients, be ***included*** *in the numerator of the Medicaid fraction*, ***and excluded*** *from the Medicare/SSI fraction*, because, by definition, those days relate to patients who were not 'entitled to' Medicare Part A benefits 'for such days' when the services were provided. Part A exhausted days and noncovered days should be excluded from the Medicare/SSI fraction for the same reason."[7]

- "Accordingly, CMS's regulation and policy requiring *including* Part A exhausted and other noncovered days in the Medicare/SSI fraction, ***and*** *excluding* such days from the numerator of the Medicaid fraction for dually-eligible patients, are 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,' 5 U.S.C. §706(2)(A), 'in excess of statutory jurisdiction, authority, or limitations, or short of statutory right,' id. §706(2)(C), and/or were not promulgated in accordance with applicable notice and comment requirements under, 42 U.S.C. §1395hh and/or 5 U.S.C. §553."[8]

Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[9] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[10]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[11] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[12]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[13] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying

[6] *Id.* at 2 (emphasis added).
[7] *Id.* at 5 (emphasis added).
[8] *Id.* at 6 (emphasis added.)
[9] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[10] *Id.*
[11] *See* 42 U.S.C. § 1395ww(d)(5).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[13] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).

hospital.[14] The DPP is defined as the sum of two fractions expressed as percentages.[15] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[16]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[17]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[18]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[19]

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

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the

[14] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[15] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[16] (Emphasis added.)
[17] 42 C.F.R. § 412.106(b)(2)-(3).
[18] (Emphasis added.)
[19] 42 C.F.R. § 412.106(b)(4).

percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[20] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[21]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[22] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[23] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[24]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[25] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[26] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[27]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[28] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it

[20] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.* at 27207-27208.
[25] *Id.* at 27207-08.
[26] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[27] 68 Fed. Reg. at 27208.
[28] *Id.*

would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended.[29] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[30]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[31] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[32]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[33] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently *misstated* our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[34]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid

[29] *Id.*
[30] *Id.*
[31] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[32] *Id.*
[33] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[34] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).

> fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[35]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[36] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[37] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[38]

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

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that--*
>
> (A) Are associated with discharges occurring during each month; and

[35] *Id.* at 49099 (emphasis added).
[36] *Id.*
[37] *See id.* at 49099, 49246.
[38] (Emphasis added.)

> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[39]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[40]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[41] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[42]

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

---

[39] (Emphasis added.)
[40] *Id.*
[41] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).
[42] (Citations omitted and emphasis added.)
[43] 317 F. Supp. 3d 168 (D.D.C. 2018).
[44] *Id.* at 172.

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

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

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

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

[45] *Id.* at 190.
[46] *Id.* at 194.
[47] *See* 2019 WL 668282.
[48] 718 F.3d 914 (2013).
[49] 657 F.3d 1 (D.C. Cir. 2011).
[50] 718 F.3d at 920.
[51] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[52] *Id.* at 1141.
[53] *Id.*
[54] *Id.* at 1162.
[55] *Id.* at 1163
[56] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).

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

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

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

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[63] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

Providers' Position

Issue Outlined in the EJR Request for the CIRP Group

The Providers in the CIRP group requested EJR to challenge the inclusion of certain Part A non-covered (*e.g.*, Part A exhausted) patient days in the Medicare fraction of the DSH calculation. The Providers argue that CMS has been inconsistent with the treatment of days for Medicare inpatients who have exhausted their Part A benefits or whose days have otherwise not been paid (Part A exhausted and other non-covered days). They note that, while historically these days

[57] *Id.* at 884.
[58] *Id.* at 884.
[59] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[60] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[61] *Id.* at 886.
[62] *Id.*
[63] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

were not counted in the Medicare fraction, CMS proposed in the FY 2004 IPPS Proposed Rule to count the days for patients who were dually-eligible in the numerator of the Medicaid fraction. However, CMS did not enact this proposal. Rather, in the FY 2005 IPPS Final Rule, CMS finalized the opposite policy: Part A exhausted and non-covered days would be counted in the Medicare fraction, and these days would be excluded from dual-eligible days in the Medicaid fraction numerator. The Providers assert that this policy change resulted in those exhausted non-covered days associated with dually eligible patients being excluded from the Medicaid fraction's numerator and only potentially being included in the Medicare fraction's numerator.[64]

The Providers contend that the policy adopted in the FY 2005 IPPS Final Rule and the associated regulatory changes were substantively and/or procedurally invalid. They claim that these no-pay Part A days should be included in the numerator of the Medicaid fraction (for the subset of those days associated with dually-eligible patients) and excluded in full from the Medicare fraction (both the numerator and denominator) because these days relate to patients who were not "entitled to" Part A benefits "for such days" when the services were provided. They state that CMS' policy deserves no deference. They contend that CMS misstated both its current and proposed policies in its FY 2004 and 2005 rulemaking, failed to provide adequate notice and opportunity for comment, and has interpreted "entitled to benefits under [Medicare Part A]" for purposes of the DSH fractions in a manner inconsistent with the statute and precedent. They note that the Ninth Circuit's decision in *Empire Health Foundation v. Azar* vacated the regulation at issue.[65] The Providers maintain EJR is appropriate because the regulation was held to be invalid and is being reviewed by the Supreme Court, and because the Board lacks the authority to review the validity of a regulation.[66]

Issue Appealed by the CIRP Group

As previously noted, this CIRP group was created after the Founding Provider transferred its Dual Eligible days issue from an individual appeal. In the individual appeal, the stated issue is simply stated as "Dual eligible days excluded from the Medicaid ***and*** SSI Ratios."[67] The "Basis for Appeal," thus, appears to describe CMS' pre-October 1, 2004 policy (*i.e.*, the policy in effect prior to the FY 2005 IPPS Final Rule) to exclude no-pay Part A days (including days associated with patients who were dual eligibles) from ***both*** the Medicare fraction and the Medicaid fraction.[68] Indeed, both the Founding Provider's transferred issue statement and the group issue statement state that the issue of the group pertains to those days that "were not included in the SSI [*i.e.*, Medicare] denominator by design" (*i.e.*, no pay dual eligible days) and were "disallowed . . . from the Medicaid numerator. Hence, ***neither*** *the Medicaid fraction* ***nor*** *the Medicare fraction captured the days associated with this indigent population.*"[69] In support of its position, both the Founding Provider and the group issue statement cite to *Edgewater Med.*

[64] EJR Request at 4-5.
[65] *Id.* at 6 (citing to 958 F.3d 873 (9th Cir. 2020).
[66] *Id.* at 5-6.
[67] (Emphasis added.)
[68] *See* CMS Ruling 1498-R2 at 3 (Apr. 22, 2015); CMS Ruling 1498-R at 7-8 (Apr. 28, 2010).
[69] (Emphasis added).

Ctr. v. Blue Cross and Blue Shield Ass'n,[70] a Board decision issued in 2000 which involved a provider's 1990 fiscal year and clearly predates the dual eligible days policy enacted in FY 2005 IPPS Final Rule, which is the subject of the instant EJR Request.

Decision of the Board

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

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [71]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[72]

For an issue to be added to an existing appeal, the request for addition must comply with the same requirements for requesting a Board hearing in an initial appeal.[73] When the underlying individual appeal was filed, the Board Rules (Mar. 1, 2013) required Providers to, for each issue under appeal, provide the basis for dissatisfaction with its final determination. With regard to identifying the issue, Providers were required to provide an issue statement that described the adjustment, ***why the adjustment was incorrect***, and how the payment should be determined differently.[74] Similarly, the regulation at 42 C.F.R. § 405.1835(b) (2014) stated:

> (b) *Contents of request for a Board hearing*. The provider's request for *a Board hearing* must be submitted in writing to the Board, and the request **must include the elements** described in

[70] PRRB Dec. 2000-D44 (Apr. 7, 2000).
[71] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[72] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[73] 42 C.F.R. § 405.1835(e).
[74] PRRB Rule 7 (Mar. 1, 2013) (emphasis added). *See also* Board Rule 8 (stating "Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7." (emphasis added)).

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

Failure to meet these requirements permits the Board to dismiss the issue with prejudice or take any other remedial action it considers appropriate.[75] A request to add an additional issue to an individual appeal is timely made if received by the Board no later than 240 days after the date of a final determination.[76]

The requirements for establishing a group appeal are similar. In this regard, 42 C.F.R. § 405.1837(c) (2014) addresses the content of a group appeal request:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.

[75] 42 C.F.R. § 405.1835(b).
[76] 42 C.F.R. § 405.1835(c)(3) (2013).

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

The Board finds that the Providers in this CIRP group have appealed only those "dual eligible days" that it alleges were excluded from ***both*** the Medicare fraction ***and*** the Medicare fraction (as reflected in the CMS policy predating the FY 2005 IPPS Final Rule).[77] The issue statement used to form the group do not refer to no-pay Part A days of which exhausted days or Medicare

[77] The issue statement associated with the individual appeals that established the group appeal clearly defines the term "dual eligible days" as used therein as those days that "were not included in the SSI [*i.e.*, Medicare] denominator by CMS' design" where "***[t]hese*** *days* were [also] disallowed as 'Medicare eligible' by the MAC from the Medicaid numerator." (Emphasis added.) Similarly, the only authority cited by the Providers in their issue statement is the Board's 2000 decision in *Edgewater* which, as discussed *supra*, clearly involved and applied the pre-October 1, 2004 policy.

secondary payor ("MSP") days are just a subset.[78] In this regard, the Board notes that a reference to "dual eligible days" for a hospital's fiscal year is clearly different than no-pay Part A days where the underlying patients associated with those days across a fiscal year largely were not Medicaid eligible and only a subset of those patients were Medicaid eligible.

In contrast, the EJR request concerns the FY 2005 IPPS Final Rule and challenges CMS' policy set forth therein to count *all* no-pay Part A days in the Medicare fraction effective for discharges on or after October 1, 2004 and seeks to include the subset of those days for which the underlying patients were also Medicaid eligible in the numerator of the Medicaid fraction. Any challenge to that policy would necessarily be a separate and distinct issue from the one appealed in the issue statement for this CIRP group. As such, the Board finds that the Providers' EJR request attempts to add issues to this CIRP group, namely: (1) the exclusion of all no-pay part A days from the Medicare fraction; and (2) the inclusion of the ***subset*** of those days, for which the underlying patients were also Medicaid eligible (*i.e.*, were dually eligible), in the numerator of the Medicaid fraction. However, 42 C.F.R. § 405.1837(f)(1) makes clear that issues may *not* be added to a group appeal after the group hearing request is filed. As such, the Board finds that it lacks jurisdiction in these appeals over the ***specific*** issue sought in its EJR Request because it was not included in the original appeals in violation of the content-specificity requirements in 42 C.F.R. §§ 405.1835(b) and 405.1837(c), and, since jurisdiction is a prerequisite to granting EJR, the Board hereby ***denies*** the EJR Request for Case No. 16-0982GC.

Finally, the Board notes that one requirement for Board jurisdiction over a group is that the group have, in the aggregate, at least $50,000 or more in controversy as specified in 42 C.F.R. § 405.1840(a). Here, each of the Providers participating in the instant CIRP group did not include a specific amount in controversy for the issue that they transferred to the instant CIRP group.[79] Thus, for purpose of demonstrating that they met the minimum $50,000 amount in controversy for purposes of forming a group, the Providers included in the final Schedule of Providers a calculation of the estimated amount in controversy for each Provider. Each of those calculations is dated March 18, 2022 and, ten (10) days later, the Providers filed the instant EJR request on March 28, 2022. Thus, it is clear that these estimates were prepared in anticipation of the instant EJR request and a review of these estimates demonstrates that they relate *only* to the issue for which the Providers seek EJR (as opposed to the issue that was originally appealed and used to form the group). Specifically, each of these estimates shows the "[p]otential impact of using covered days (per CMS) with the decrease in SSI days added to Medi-Cal." For example, the estimated amount in controversy included for Orange Coast at Tab 3E of the Schedule of Providers where Orange Coast's DSH payment would increase by an estimated $74,514 due to: (1) an increase in the Medicare fraction from 16.19 percent to 16.50 percent by *removing* no pay

[78] The Board looked to both the group issue statement *and* the issue statement transferred in by the Founding Provider since the group cannot be any more than the issue that the Founding Provider had appealed and was transferring into the group. In other words, the Founding Provider can only transfer what it had already established in its individual appeal (anything more would be have to be properly added to the individual appeal prior to transfer) and the CIRP group only exists by virtue of the Founding Provider which means it can be no more than what the Founding Provider transfers.

[79] The individual appeals for each of these providers included multiple issues and, rather than giving an amount in controversy for each issue, each provider relied on the issues in the aggregate to meet the minimum $10,000 amount in controversy required for an individual appeal. *See* 42 C.F.R. § 405.1839(a)(2).

Part A days (as relevant, from both the numerator and denominator of the Medicare fraction) so that only "covered days" remain; and (2) an increase in the number of Medi-Cal Eligible days from 3,359 to 3,403 as used in the numerator of the Medicaid fraction. Thus, these estimates clearly either an increase or a decrease to the Medicare fraction (by removing any no-pay Part A days, as relevant from the numerator and denominator of the Medicare fraction[80]) and an increase to the Medicaid fraction (by including in the numerator of the Medicaid fraction the subset of those removed days that pertain to dual eligibles).[81] In contrast, the issue statement used to form the CIRP group relates *only* to the class of dual eligible days that were excluded from ***both*** the Medicare and Medicaid fractions (*i.e.*, the days at issue are only those dual eligible days excluded from the Medicare and Medicaid fractions) and, as such, the Medicare fraction would never reflect a change (increase or decrease) for purposes of calculating an estimated amount in controversy *based on the issue statement used to form the CIRP group*. Based on the above findings, it is clear that the record for the *fully-formed* group does not contain any estimated amount in controversy *for the group issue for which it was formed*.

Pursuant to 42 C.F.R. § 405.1837(a)(3), the amount in controversy for a group is determined in accordance with § 405.1839, which states, in pertinent part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under §405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000.
>
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues.
>
> (A) A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in §405.1837(a)(2) of this subpart).

[80] Whether the removal of the no-pay Part A days results in a decrease versus an increase in the Medicare fraction depends on how many of these days involve patients who are also SSI recipients since the subset of days associated with these SSI recipients are removed not only from the denominator of the Medicare fraction but also from the numerator of the Medicare fraction.

[81] Moreover, the Board notes that the CMS policy in effect *during the time at issue in this CIRP group* was to count all no-pay Part A days in the Medicare fraction (including those associated with patients who were also Medicaid eligible). Accordingly, if an amount in controversy had been calculated for the class of days *covered by the group issue statement* (*i.e.*, those dual eligible days that were excluded from ***both*** the Medicare *and* Medicaid fractions), it would appear that the amount in controversy for this CIRP group would be close to zero (*i.e.*, below the minimum $50,000 threshold) since, under that policy, there would be no dual eligible days excluded from both the Medicare and Medicaid fractions during the years at issue. To the extent any dual eligible days were, ***in fact***, excluded from both fractions (as alleged but yet contrary to that policy), then that would be a factual issue and would presumably be similar to the systemic data match issues raised in the *Baystate* litigation. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, Adm'r Dec. (May 11, 2006); *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008).

> (B) The single issue that is common to each provider may exist over different cost reporting periods.
>
> (ii) For purposes of satisfying the amount in controversy requirement, a provider may appeal multiple cost reporting periods and different providers in the group may appeal different cost reporting periods.

In addition, § 405.1837(e)(2) makes clear that the Board may consider dismissing a group appeal hearing request for failure to meet that requirement once the group is *fully formed*.

Here, it is clear that the CIRP group is ***fully formed*** and that the Providers have failed to demonstrate that they meet the $50,000 amount in controversy requirement *for the issue covered by the group*. Rather, they have attempted to add an issue to the group and, in the documentation submitted to demonstrate the Board's jurisdiction over this group, they have alleged an amount in controversy for this added issue. As previously noted, adding issues to group appeals is prohibited by regulation. As the group is fully formed and the providers have failed to establish they meet the amount in controversy *for the issue appealed by the group*, the Board hereby dismisses the group appeal pursuant to its authority under 42 C.F.R. §§ 405.1837(e)(2) and 42 C.F.R. § 405.1868(b)(2).

Further, the facts that a group appeal may contain only one issue and that the EJR request, along with estimated amounts in controversy, were submitted on an issue other than the one for which the group appeal was established, the Board must conclude that the Providers have abandoned the original group issue. This serves as an alternate, and independent, basis for dismissal.[82]

* * * * *

In summary, the Board denies the EJR request and dismisses the CIRP group (including all the remaining participants therein, as shown on the attached Schedule of Providers). Accordingly, the Board closes this CIRP group and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

---

[82] This is analogous to Board Rules governing position papers which specify that "If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Board Rule 25.3 (Nov. 2021). Further Board Rule 41.2 specifies:

> The Board may dismiss a case or an issue on its own motion:
>
> - If it has a reasonable basis to believe that the issues have been fully settled or abandoned:
> - Upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868); . . . .

Board Members Participating:

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

FOR THE BOARD:

5/9/2022

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nina Marsden, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Ste 1600
Los Angeles, CA 90067

RE: ***EJR Determination***
MHS 2009 Dual Eligible CIRP Group
Case No. 14-3911GC

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 28, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal. The decision of the Board to *deny* EJR is set forth below.

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

By letter dated April 25, 2022, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group case consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On March 22, 2022, subsequent to the submission of the EJR request in this appeal, the Board notified you of the relevance of Alert 19 to the EJR request. In particular, the Board notified you of the following:

> As the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under" the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b).

In this regard, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "***only if*** . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days ***after*** finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete."[1] Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[2]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. The issuance of this determination completes the Board jurisdictional review process and the Board is concurrently issuing its determination on the EJR request as the Board is familiar with the legal issues raised in the EJR request and has previously issued similar EJR determinations for those legal issues.

II. Issue in Dispute

This CIRP group consists of 5 participants and 4 of them were used to establish this CIRP group. Specifically, the four founding providers are: (1) Community Hospital of Long Beach ("Community") ; (2) Orange Coast Memorial Medical Center ("Orange"); (3) Anaheim Memorial Medical Center ("Anaheim"); and (4) Saddleback Memorial Medical Center ("Saddleback"). Collectively the Board will hereinafter refer to Community, Orange, Anaheim, and Saddleback as the "Founding Providers". The Founding Providers initially filed transfer requests to join the CIRP group under Case No. 09-2332GC entitled "MHS 10/1/2004-2007 Dual Eligible CIRP Group." However, by letter dated August 12, 2014, the Board found that the requested transfers were outside the fiscal years approved for Case No. 09-2332GC, and it denied expansion of that CIRP group.[3] As a result of these rulings, the Board, therein, took the

[1] (Emphasis added.)
[2] (Emphasis added.)
[3] Board Letter re: Requests to Transfer Providers into MHS 10/1/2004-2007 Dual Eligible CIRP Group, Case No. 09-2332GC (Aug. 12, 2014). The Board notes that Case No. 09-2332GC is still open and pending before the Board. Case No. 09-2332GC originally included DSH dual eligible days for discharges prior to October 1, 2004 but, in

alterative action of establishing the instant single-year CIRP group covering 2009 under Case No. 14-3911GC.[4]

As no group issue statement was filed to establish the instant CIRP group (and the providers were not transferring from a group), the issue transferred by the Founding Providers from their respective individual appeals, governs the group issue statement. Here, 3 of the 4 Founding Providers (Orange, Anaheim, and Saddleback) had the same issue statement in their individual appeals for the issue that they transferred to the instant CIRP group.[5] That issue statement for these 3 Founding Providers reads as follows:

> ISSUE: Dual eligible days *excluded from the Medicaid* ***and*** *SSI ratios*.

October 2013, the Board bifurcated those pre-October 1, 2004 days into Case No. 13-3960GC. Indeed, Case No. 09-2332GC was formed on or about September 14, 2009 and appears to be a bifurcation from (or, at a minimum, related to) Case No. 09-2176GC entitled "MHS 1996 – 2003 DSH Dual Eligibles CIRP Group," which was established via an appeal request filed on August 26, 2009 that included certain FY 2004 providers that ultimately ended up in Case No. 09-2332GC. As explained in CMS Ruling 1498-R, CMS' policy prior to October 1, 2004 was to exclude no-pay Part-A days (including the subset associated with dual eligible) from both the Medicare and Medicaid fractions:

> Hospitals have also filed DSH appeals to the PRRB challenging the **exclusion** from the DPP of non-covered inpatient hospital days for patients entitled to Medicare Part A, including appeals of days for which the patient's Part A hospital benefits were exhausted. Under CMS' original policy, inpatient days were included in the numerator of the DSH SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the SSI fraction. *See, e.g.*, 42 C.F.R. § 412.106(b)(2)(i) (2003). CMS' original policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were **excluded** from the numerator of the DSH Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days in its Medicare cost report). *See* 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004) ("FY 2005 IPPS final rule").

CMS Ruling 1498-R at 7-8 (Apr. 28, 2010) (bold emphasis added).

[4] *Id.* The Board notes that, as part of this correspondence, the Board also denied other transfer requests relating to other years and the Board similarly established MHS CIRP groups for these other years.

[5] In contrast to the other 3 Founding Providers, Community requested to transferred "The exclusion of Dual Eligible days for the computation of the SSI% -- Adjustments #24, 25." Schedule of Providers for Case No. 14-3911GC at Tab 5G. This matches the description of Issue 2 wherein "[t]he Provider is appealing the exclusion of dual eligible days in the computation of the correct SSI%." Indeed, the cover letter describes the issue being transferred by quoting the following sentences from "Legal Basis" for Issue 2: "The [P]rovider contends that the dual eligible Medicare patients should not be ***excluded*** from the eligible days for the SSI computation. As such the Provider contends that the Medicare fraction in its disproportionate share payment has not been calculated in accordance with Medicare regulations and [M]anuals provisions as described in 42 C.F.R. § 412.106." While Issue 2 pertains to the same class of days (*i.e.*, those dual eligible days excluded from the SSI fraction), it is requesting the relief that is the opposite of the other 3 Founding Providers, namely Community is seeking the *inclusion* of those excluded days in the SSI fraction. The Board's conclusion that Community's transfer request to Case No. 14-3911GC was for Issue 2 is further supported by the facts that: (1) the Provider's appeal request only enumerated 3 issues; (2) the Provider first transferred two issues to other groups (Issue 1 to Case No. 14-0456GC for Part C Days and Issue 3 to Case No. 14-0456GC for SSI % accuracy); and (3) on October 9, 2014, the Board closed the Community's individual case after transferring the remaining issue (*i.e.*, Issue 2) to Case No. 14-3911GC.

> BRIEF DESCRIPTION: Whether the MAC utilized the appropriate Medicaid and/or SSI ratios in the calculation of the DSH and LIP adjustments as *dual eligible days were excluded from **both** ratios*.
>
> . . . .
>
> BASIS FOR APPEAL: 42 C.F.R. § 412.106(b), 412.320 and 412.624(e)
>
> Dual eligible days are patient days associated with those patients who were ***not** included in the SSI denominator by CMS' design* as they were not directly billed to Medicare and did not flow through the [MEDPAR] system. ***These days*** are disallowed as "Medicare eligible" by the MAC from the Medicaid numerator. Hence, *neither the Medicaid fraction nor the Medicare fraction captured the days associated with this indigent population.*
>
> Dual eligible days were excluded from the Medicaid fraction for a variety of reasons. By way of example, some dual eligible days are associated with patients who are eligible for Medicaid by have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL) v. Blue Cross and Blue Shield Association . . . , PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held:
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. [citations omitted].
>
> Thus, in accordance with the Board's holding in Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days". . . .[6]

As the majority of the Founding Providers (3 of 4) had the above issue, the Board finds that it is what formed the group issue statement.[7] The final provider that transferred after the group was established is Long Beach Memorial Medical Center ("Memorial") and Memorial transferred in

[6] *E.g.*, PRRB Case 13-3739, Individual Appeal Request, Issue 5 (Sept. 19, 2013) (emphasis added).
[7] The group issue must be common to all participants in the group and the Board is dismissing Community as explained at *infra* note 85 and accompanying text.

this exact same issue from its individual appeal. As a result, 4 out of 5 providers in the group transferred in the above issue into the group.

In contrast, the EJR request for the CIRP group frames the legal question as follows:

> The Group Appeal challenges the regulation and policy of [CMS], promulgated as part of the FY 2005 IPPS Final Rule, to count exhausted or otherwise non-covered days for patients eligible for Medicare *in the Medicare/SSI fraction* and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction, as adopted and applied by CMS for purposes of calculating the Hospitals' Medicare [DSH] payments during their respective fiscal years included in the Group Appeal.[8]

The following excerpts from this EJR request shed additional light on the nature of this legal question:

- "As Section III below shows, the Hospitals are challenging the validity of CMS's regulation and policy to count exhausted or otherwise non-covered days for patients eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction."[9]

- "Part A exhausted or noncovered days should, for dually-eligible patients, be ***included*** *in the numerator of the Medicaid fraction,* ***and*** ***excluded*** *from the Medicare/SSI fraction*, because, by definition, those days relate to patients who were not 'entitled to' Medicare Part A benefits 'for such days' when the services were provided. Part A exhausted days and noncovered days should be excluded from the Medicare/SSI fraction for the same reason."[10]

- "Accordingly, CMS's regulation and policy requiring *including* Part A exhausted and other noncovered days in the Medicare/SSI fraction, ***and*** *excluding* such days from the numerator of the Medicaid fraction for dually-eligible patients, are 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,' 5 U.S.C. §706(2)(A), 'in excess of statutory jurisdiction, authority, or limitations, or short of statutory right,' id. §706(2)(C), and/or were not promulgated in accordance with applicable notice and comment requirements under, 42 U.S.C. §1395hh and/or 5 U.S.C. §553."[11]

---

[8] Request for Expedited Judicial Review, 1-2 (Mar. 28, 2022) ("EJR Request").
[9] *Id.* at 2 (emphasis added).
[10] *Id.* at 5 (emphasis added).
[11] *Id.* at 6 (emphasis added.)

Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[12] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[13]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[14] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[15]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[16] 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.[17] The DPP is defined as the sum of two fractions expressed as percentages.[18] 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 . . . .[19]

[12] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[13] *Id.*
[14] *See* 42 U.S.C. § 1395ww(d)(5).
[15] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[16] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[17] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[18] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[19] (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 an eligible hospital's DSH payment adjustment.[20]

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.[21]

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.[22]

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

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[23] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[24]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[25] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage

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

is exhausted.[26] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[27]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[28] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[29] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[30]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[31] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [32] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[33]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[34] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[35]

---

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

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[36] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently *misstated* our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[37]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[38]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted

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

Medicare Part A hospital coverage."[39] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[40] Prior to this revision, § 412.106(b)(2) (2004) had stated:

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

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

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that--*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[42]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[43]

---

[39] *Id.*
[40] *See id.* at 49099, 49246.
[41] (Emphasis added.)
[42] (Emphasis added.)
[43] *Id.*

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[44] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[45]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[46] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[47] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[48] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[49] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[50] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

---

[44] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).
[45] (Citations omitted and emphasis added.)
[46] 317 F. Supp. 3d 168 (D.D.C. 2018).
[47] *Id.* at 172.
[48] *Id.* at 190.
[49] *Id.* at 194.
[50] *See* 2019 WL 668282.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[51] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[52] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[53]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[54] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[55] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[56] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[57] and that the regulation is procedurally invalid.[58]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[59] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[60] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[61] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[62] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

---

[51] 718 F.3d 914 (2013).
[52] 657 F.3d 1 (D.C. Cir. 2011).
[53] 718 F.3d at 920.
[54] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[55] *Id.* at 1141.
[56] *Id.*
[57] *Id.* at 1162.
[58] *Id.* at 1163
[59] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[60] *Id.* at 884.
[61] *Id.* at 884.
[62] 97 F.3d 1261, 1265-66 (9th Cir. 1996).

Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[63] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[64] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[65] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[66] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

III. Providers' Position

Issue Outlined in the EJR Request for the CIRP Group

The Providers in the CIRP group requested EJR to challenge the inclusion of certain Part A non-covered (*e.g.*, Part A exhausted) patient days in the Medicare fraction of the DSH calculation. The Providers argue that CMS has been inconsistent with the treatment of days for Medicare inpatients who have exhausted their Part A benefits or whose days have otherwise not been paid (Part A exhausted and other non-covered days). They note that, while historically these days were not counted in the Medicare fraction, CMS proposed in the FY 2004 IPPS Proposed Rule to count the days for patients who were dually-eligible in the numerator of the Medicaid fraction. However, CMS did not enact this proposal. Rather, in the FY 2005 IPPS Final Rule, CMS finalized the opposite policy: Part A exhausted and non-covered days would be counted in the Medicare fraction, and these days would be excluded from dual-eligible days in the Medicaid fraction numerator. The Providers assert that this policy change resulted in those exhausted non-covered days associated with dually eligible patients being excluded from the Medicaid fraction's numerator and only potentially being included in the Medicare fraction's numerator.[67]

[63] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[64] *Id.* at 886.
[65] *Id.*
[66] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).
[67] EJR Request at 4-5.

The Providers contend that the policy adopted in the FY 2005 IPPS Final Rule and the associated regulatory changes were substantively and/or procedurally invalid. They claim that these no-pay Part A days should be included in the numerator of the Medicaid fraction (for the subset of those days associated with dually-eligible patients) and excluded in full from the Medicare fraction (both the numerator and denominator) because these days relate to patients who were not "entitled to" Part A benefits "for such days" when the services were provided. They state that CMS' policy deserves no deference. They contend that CMS misstated both its current and proposed policies in its FY 2004 and 2005 rulemaking, failed to provide adequate notice and opportunity for comment, and has interpreted "entitled to benefits under [Medicare Part A]" for purposes of the DSH fractions in a manner inconsistent with the statute and precedent. They note that the Ninth Circuit's decision in *Empire Health Foundation v. Azar* vacated the regulation at issue.[68] The Providers maintain EJR is appropriate because the regulation was held to be invalid and is being reviewed by the Supreme Court, and because the Board lacks the authority to review the validity of a regulation.[69]

Issue Appealed by the CIRP Group

As previously noted, this CIRP group was created after the Founding Providers sought to transfer Dual Eligible days issues from several individual appeals and the group issue for this CIRP group was set based on the issue transferred by the 3 of those 4 Founding Providers.[70] In the individual appeals for those 3 Founding Providers, the stated issue is simply stated as "Dual eligible days excluded from the Medicaid ***and*** SSI Ratios."[71] The "Basis for Appeal," thus, appears to describe CMS' pre-October 1, 2004 policy (*i.e.*, the policy in effect prior to the FY 2005 IPPS Final Rule) to exclude no-pay Part A days (including days associated with patients who were dual eligibles) from ***both*** the Medicare fraction and the Medicaid fraction.[72] Indeed, the appealed issue states that it pertains to those days that "were not included in the SSI [*i.e.*, Medicare] denominator by design" (*i.e.*, no pay dual eligible days) and were "disallowed . . . from the Medicaid numerator. Hence, ***neither*** *the Medicaid fraction* ***nor*** *the Medicare fraction captured the days associated with this indigent population.*"[73] In support of their position, the Providers cite to *Edgewater Med. Ctr. v. Blue Cross and Blue Shield Ass'n*,[74] a Board decision issued in 2000 which involved a provider's 1990 fiscal year and clearly predates the dual eligible days policy enacted in FY 2005 IPPS Final Rule, which is the subject of the instant EJR Request.

---

[68] *Id.* at 6 (citing to 958 F.3d 873 (9th Cir. 2020).
[69] *Id.* at 5-6.
[70] Board Letter re: Requests to Transfer Providers into MHS 10/1/2004-2007 Dual Eligible CIRP Group, Case No. 09-2332GC (Aug. 12, 2014).
[71] (Emphasis added.)
[72] *See* CMS Ruling 1498-R2 at 3 (Apr. 22, 2015); CMS Ruling 1498-R at 7-8 (Apr. 28, 2010). The relationship of this appeal to other MHS CIRP cases with pre-2004 fiscal years challenging CMS' policy in effect prior to the changes made in the FY 2005 IPPS Final Rule supports this conclusion. *See supra* note 3.
[73] (Emphasis added).
[74] PRRB Dec. 2000-D44 (Apr. 7, 2000).

IV. Decision of the Board

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

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [75]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[76]

For an issue to be added to an existing appeal, the request for addition must comply with the same requirements for requesting a Board hearing in an initial appeal.[77] When the underlying individual appeals were filed, the Board Rules (Mar. 1, 2013) required Providers to, for each issue under appeal, provide the basis for dissatisfaction with its final determination. With regard to identifying the issue, Providers were required to provide an issue statement that described the adjustment, ***why the adjustment was incorrect***, and how the payment should be determined differently.[78] Similarly, the regulation at 42 C.F.R. § 405.1835(b) (2013) stated:

> (b) *Contents of request for a Board hearing*. The provider's request for *a Board hearing* must be submitted in writing to the Board, and the request **must include the elements** described in paragraphs (b)(1) through (b)(4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraphs (b)(1), (b)(2), or (b)(3) of this section, **the Board may**

[75] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[76] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[77] 42 C.F.R. § 405.1835(e).
[78] PRRB Rule 7 (Mar. 1, 2013) (emphasis added). *See also* Board Rule 8 (stating "Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7." (emphasis added)).

> **dismiss with prejudice** the appeal, or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section . . . .
>
> (2) An explanation (for **each** specific item at issue, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for **each** disputed item (or where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to the underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.

Failure to meet these requirements permits the Board to dismiss the issue with prejudice or take any other remedial action it considers appropriate.[79] A request to add an additional issue is timely made if received by the Board no later than 240 days after the date of a final determination.[80]

The requirements for establishing a group appeal are similar. In this regard, 42 C.F.R. § 405.1837(c) (2014) addresses the content of a group appeal request:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.

[79] 42 C.F.R. § 405.1835(b).
[80] 42 C.F.R. § 405.1835(c)(3) (2013).

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

The Board finds that the Providers in this CIRP group have appealed only those "dual eligible days" that it alleges were excluded from ***both*** the Medicare fraction ***and*** the Medicare fraction (as reflected in the CMS policy predating the FY 2005 IPPS Final Rule).[81] As discussed in

[81] The issue statement associated with the individual appeals of Orange, Anaheim and Saddleback that established the group appeal clearly defines the term "dual eligible days" as used therein as those days that "were not included in the SSI [*i.e.*, Medicare] denominator by CMS' design" where "***[t]hese*** *days* were [also] disallowed as 'Medicare eligible' by the MAC from the Medicaid numerator." (Emphasis added.) The relationship of this appeal to other MHS CIRP cases appealing this same class of days and challenging CMS' policy in effect prior to the changes made in the FY 2005 IPPS Final Rule support this conclusion. *See supra* note 3. Similarly, the only authority cited by the Providers in their issue statement is the Board's 2000 decision in *Edgewater* which, as discussed *supra*, clearly

Section II, the issue statements of Orange, Anaheim and Saddleback served to establish the issue statement for this group; however, these issue statements do not refer to no-pay Part A days such as exhausted days or Medicare secondary payor ("MSP") days. In this regard, the Board notes that a reference to "dual eligible days" for a hospital's fiscal year is clearly different than no-pay Part A days where the underlying patients associated with those days across a fiscal year largely were not Medicaid eligible and only a subset of those patients were Medicaid eligible.

In contrast, the EJR request concerns the FY 2005 IPPS Final Rule and challenges CMS' policy set forth therein to count *all* no-pay Part A days in the Medicare fraction effective for discharges on or after October 1, 2004 and seeks to include the subset of those days for which the underlying patients were also Medicaid eligible in the numerator of the Medicaid fraction. Any challenge to that policy would necessarily be a separate and distinct issue from the one appealed in the issue statement for this CIRP group. As such, the Board finds that the Providers' EJR request attempts to add issues to this CIRP group, namely: (1) the exclusion of all no-pay part A days from the Medicare fraction; and (2) the inclusion of the ***subset*** of those days, for which the underlying patients were also Medicaid eligible (*i.e.*, were dually eligible), in the numerator of the Medicaid fraction. However, 42 C.F.R. § 405.1837(f)(1) makes clear that issues may *not* be added to a group appeal after the group hearing request is filed. As such, the Board finds that it lacks jurisdiction in these appeals over the ***specific*** issue sought in its EJR Request because it was not included in the original appeals, and, since jurisdiction is a prerequisite to granting EJR, the Board hereby ***denies*** the EJR Request for Case No. 14-3911GC.

Finally, the Board notes that one requirement for Board jurisdiction over a group is that the group have, in the aggregate, at least $50,000 or more in controversy as specified in 42 C.F.R. § 405.1840(a). Here, each of the Providers participating the instant CIRP group did not include a specific amount in controversy for the issue that they transferred to the instant CIRP group.[82] Thus, for purpose of demonstrating that they met the minimum $50,000 amount in controversy for purposes of forming a group, the Providers included in the final Schedule of Providers a calculation of the estimated amount in controversy for each Provider. Each of those calculations is dated March 18, 2022 and, 10 days later, the Providers filed the instant EJR request on March 28, 2022. Thus, it is clear that these estimates were prepared in anticipation of the instant EJR request and a review of these estimates demonstrates that they relate *only* to the issue for which the Providers seek EJR (as opposed to the issue that was originally appealed and used to form the group). Specifically, each of these estimates shows the "[p]otential impact of using covered days (per CMS) with the decrease in SSI days added to Medi-Cal." For example, the estimated amount in controversy included for Anaheim at Tab 1E of the Schedule of Providers where

---

involved and applied the pre-October 1, 2004 policy. The remaining Founding Provider was Community and, as discussed in *supra* note 5, Community similarly transferred an issue that pertained to dual eligible days excluded from the SSI fraction but, unlike the other Founding Providers, it sought to include them in the SSI fraction (as opposed to the Medicaid fraction).

[82] The individual appeals for each of these providers included multiple issues and, rather than giving an amount in controversy for the issue that is the subject of this appeal (*i.e.*, the Provider did not give an estimated amount in controversy for the issue that was transferred to this appeal), each provider relied on the issues in the aggregate to meet the minimum $10,000 amount in controversy required for an individual appeal. *See* 42 C.F.R. § 405.1839(a)(2).

Anaheim's DSH payment would increase by an estimated $74,206 due to: (1) an increase in the Medicare fraction from 18.31 percent to 18.59 percent by *removing* no pay Part A days so that only "covered days" remain; and (2) an increase the number of Medi-Cal Eligible days from 3,988 to 4,014 as used in the numerator of the Medicaid fraction. Thus, these estimates clearly show either an increase or decrease to the Medicare fraction (by removing any no-pay Part A days, as relevant from the numerator and denominator of the Medicare fraction[83]) and an increase to the Medicaid fraction (by including in the numerator of the Medicaid fraction the subset of those removed days that pertain to dual eligibles). In contrast, the issue statement used to form the group relates *only* to the class of dual eligible days that were excluded from ***both*** the Medicare and Medicaid fractions (*i.e.*, the days at issue are only those dual eligible days excluded from the Medicare and Medicaid fractions) and, as such, the Medicare fraction would never reflect a change (increase or decrease) for purposes of calculating an estimated amount in controversy *based on the issue statement used to form the CIRP group*.[84,85] Based on the above

[83] Whether the removal of the no-pay Part A days results in a decrease versus an increase in the Medicare fraction depends on how many of these days involve patients who are also SSI recipients since the subset of days associated with these SSI recipients are removed not only from the denominator of the Medicare fraction but also from the numerator of the Medicare fraction.

[84] Moreover, the Board notes that the CMS policy in effect *during the time at issue in this CIRP group* was to count all no-pay Part A days in the Medicare fraction (including those associated with patients who were also Medicaid eligible). Accordingly, if an amount in controversy had been calculated for the class of days *covered by the group issue statement* (*i.e.*, those dual eligible days that were excluded from ***both*** the Medicare *and* Medicaid fractions), it would appear that the amount in controversy for this CIRP group would be close to zero (*i.e.*, below the minimum $50,000 threshold) since, under that policy, there would be no dual eligible days excluded from both the Medicare and Medicaid fractions during the years at issue. To the extent any dual eligible days were, ***in fact***, excluded from both fractions (as alleged but yet contrary to that policy), then that would be a factual issue and would presumably be similar to the systemic data match issues raised the *Baystate* litigation. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, Adm'r Dec. (May 11, 2006); *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37 (D.D.C. 2008).

[85] The Board recognizes that, as discussed in *supra* note 5, Community did not transfer the issue that is the subject of this group and, as such, is ***not*** a proper participant in this group. As such, it is appropriate to dismiss Community. Moreover, the Board has no obligation to transfer Community because: (1) there is no open individual appeal for Community (Case No. 13-3536 was closed on October 9, 2014) and the 3 year period for reinstating that appeal is well passed); (2) there is no stated amount in controversy for the Issue 2 that Community transferred to Case No. 14-3911GC since the issue statement for the individual appeal stated "The exact dollar amount cannot be determined at this time because the information necessary to make these calculations is not in the Provider's possession"; (3) 42 C.F.R. § 405.1837(e)(5)(ii) is not applicable since it applies to group formation and Community's issue does not qualify for an individual appeal (does not meet the minimum amount in controversy). Moreover, the amount in controversy included with the Schedule of Providers behind Tab 5E for Community clearly does not pertain to the Issue 2 as stated in Community's appeal request because Issue 2 sought to include excluded dual eligible days in the Medicare fraction and did not seek any change to the Medicaid fraction while, in contrast, the calculation at Tab 5E shows the removal of no-pay Part A days from the Medicare fraction and the addition of no-pay Part A days pertaining to dual eligible days to the Medicaid fraction. Indeed, the very problems identified with the amount in controversy for the other providers, as discussed in *supra* note 84, is equally applicable to Community where the difference is the relief requested. Further, a separate and independent basis for dismissal is that, to the extent Community had any basis to request bifurcation from the group, Community abandoned it since it has been roughly 8 years since it joined the group and was included both as part of the final Schedule of Providers (*i.e.*, a certification by MHS that the Board had jurisdiction over Community as part of this group) and the EJR request (similar to the other participants as discussed at *supra* note 86 and accompanying text) even though Community clearly had no right to join the CIRP group based on the issue that Community appealed and transferred.

findings, it is clear that the *fully-formed* group does not have any estimated impact on the group issue for which it was formed.

Pursuant to 42 C.F.R. § 405.1837(a)(3), the amount in controversy for a group is determined in accordance with § 405.1839, which states, in pertinent part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under §405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000.
>
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues.
>
> (A) A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in §405.1837(a)(2) of this subpart).
>
> (B) The single issue that is common to each provider may exist over different cost reporting periods.
>
> (ii) For purposes of satisfying the amount in controversy requirement, a provider may appeal multiple cost reporting periods and different providers in the group may appeal different cost reporting periods.

In addition, § 405.1837(e)(2) makes clear that the Board may consider dismissing a group appeal hearing request for failure to meet that requirement once the group is *fully formed*.

Here, it is clear that the CIRP group is ***fully formed*** and that the Providers have failed to demonstrate that they meet the $50,000 amount in controversy requirement *for the issue covered by the group*. Rather, they have attempted to add an issue to the group and alleged an amount in controversy for this added issue. As previously noted, adding issues to group appeals is prohibited by regulation. As the group is fully formed and the providers have failed to establish they meet the amount in controversy *for the issue appealed by the group*, the Board hereby dismisses the group appeal pursuant to its authority under 42 C.F.R. §§ 405.1837(e)(2) and 42 C.F.R. § 405.1868(b)(2).

Further, the facts that a group appeal may contain only one issue and that the EJR request, along with estimated amounts in controversy, were submitted on an issue other than the one for which

the group appeal was established, the Board must conclude that the Providers have abandoned the original group issue. This serves as an alternate, and independent, basis for dismissal.[86]

* * * * *

In summary, the Board denies the EJR request and dismisses the CIRP group (including all the remaining participants therein, as shown on the attached Schedule of Providers). Accordingly, the Board closes this CIRP group and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

FOR THE BOARD:

5/11/2022

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS

[86] This is analogous to Board Rules governing position papers which specify that "If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Board Rule 25.3 (Nov. 2021). Further Board Rule 41.2 specifies:

> The Board may dismiss a case or an issue on its own motion:
>
> - If it has a reasonable basis to believe that the issues have been fully settled or abandoned:
> - Upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868); . . . .

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Robert Roth, Esq.
Hooper, Lundy & Bookman, P.C.
401 9th Street, N.W., Ste. 550
Washington, DC 20004

RE: ***Expedited Judicial Review Decision***
17-2135GC UNC Healthcare System 2013 Medicare DSH Exhausted/MSP Days Medicaid & Medicare/SSI Fractions CIRP Group

Dear Mr. Roth:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 15, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal. The decision of the Board is set forth below.

I. Issue in Dispute

The Providers describe the issue in this CIRP group appeal as follows:

> UNC Healthcare System FY 2013 Medicare DSH Exhausted/MSP Days Medicaid and Medicare/SSI Fractions CIRP Group Appeal:
>
> Whether the Hospitals' FY 2013 Medicare DSH payments were improperly low because of the failure to properly account for inpatient days for which there was no Medicare coverage or for which Medicare did not make a Part A payment, including but not limited to Medicare Part A exhausted days, Medicare managed care days, Medicare Secondary Payer days, Medicare medical denials, and Medicare technical denials. These days should be excluded from the Medicare/SSI Fraction and, for dually-eligible inpatients, included in the Medicaid Fraction. The Hospitals' FY 2013 DSH calculations were made pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(v) and (vi), based on the Hospitals' DSH percentage. The DSH percentage is the sum of two fractions, which are designed to capture the number of low-income patients a hospital serves on an inpatient basis. The first fraction, referred to as the "Medicaid Fraction," accounts for inpatients who are not entitled to Medicare benefits, but who qualify for medical

> assistance under a State's Medicaid State plan. The second fraction, referred to as the "Medicare/SSI Fraction," accounts for inpatients who are entitled to Medicare and SSI, a federal low-income supplement. In order for DSH payments to be calculated properly, all inpatient days from low-income patients of a hospital need to be included within one of these fractions.
>
> For exhausted/MSP days, the patients are not "entitled" to Part A. Thus, the DSH payment calculations at issue were incorrect because inpatient days related to (a) inpatients with exhausted/MSP days were improperly included in the Medicare/SSI fraction and (b) dually-eligible inpatients with exhausted/MSP days were improperly excluded from the numerator of the Medicaid fraction. [1]

In the Providers' Request for EJR they frame the legal question as follows:

> The Group Appeal challenges the substantive and procedural validity of the rule that the Centers for Medicare & Medicaid Services ("CMS") adopted in the federal fiscal year ("FFY") 2005 Inpatient Prospective Payment System ("IPPS") Final Rule for determining the inpatient days for which a patient is "entitled to" Medicare Part A benefits for purposes of calculating Medicare disproportionate share hospital ("DSH") payments. Specifically, the Hospitals contend that their DSH payments at issue were not made in accordance with law because CMS's FFY 2005 rule does not properly account for determining inpatient days attributable to patients where there was no Medicare coverage or where Medicare did not make a Part A payment, including but not limited to Part A exhausted days, Medicare medical denials, Medicare technical denials, medically-unnecessary days, custodial care days, and MSP days ("Part A exhausted and non- covered days") in the statutory DSH payment formula. The Hospitals contend that CMS's rule improperly requires treating Part A exhausted and non-covered days as days for which the patient was "entitled to" Medicare Part A.[2]

The Board notes that the Board has required the formation of two separate groups for the Exhausted Part A Days issue as it relates to the SSI and Medicaid Fractions as there are two legal issues involved issue statement. Specifically, the Board has required bifurcation of cases such as these to parse out a CIRP group for the "SSI Fraction/Dual Eligible Days" issue, which challenges the inclusion of noncovered Medicare days in the SSI fraction (as mandated by the regulatory revisions made by the FY 2005 IPPS Final Rule); and a CIRP group for the "Medicaid

[1] Notice of Request for Formation of Four Mandatory Group Appeals Based on Transfers From Currently Pending Individual Appeals at 2, "Issue 1," (Aug. 25, 2017).
[2] Request for Expedited Judicial Review at 1-2 (Apr. 15, 2022) ("EJR Request").

Fraction/Dual Eligible Days" issue, which alleges that, if the days at issue are excluded from the SSI fraction (*i.e.*, following a successful reversal of the regulatory revisions made by the FY 2005 IPPS Final Rule), then the subset of days that are associated with Medicaid eligible patients should be included in the numerator of the Medicaid fraction (as opposed to simply being excluded from the SSI fraction and the numerator of the Medicaid fraction as was done prior to the FY 2005 IPPS Final Rule).

The Board notes that the group issue statement in this case contains a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions. The statute and regulations governing group appeals specifically note that a provider has a right to a Board hearing as part of a group appeal with other providers "***only if*** . . . [t]he matter at issue in the group appeal involves a ***single*** quest of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group[.]"[3] Further, "[w]hen the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."[4]

As discussed below in Section IV.B, since the Board has determined jurisdiction is proper for all participants for both issues, and for the sake of judicial economy, the Board is hereby bifurcating this CIRP Group Appeal into the following cases, as reflected in the attached Schedules of Providers:

- 17-3125GC(A): UNC Healthcare 2013 Exhausted/MSP Days CIRP Group/SSI Fraction
- 17-3125GC(B): UNC Healthcare 2013 Exhausted/MSP Days CIRP Group/Medicaid Fraction[5]

II. Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

---

[3] 42 C.F.R. § 405.1837(a)(2). *See also* 42 U.S.C. 1395oo(b) (noting that a group appeal is proper "***only if*** the matters in controversy involve a common question of fact or interpretation of law or regulations . . .").
[4] 42 C.F.R. § 405.1837(f)(2)(ii).
[5] As these cases have the same record up to this point and there will be no further proceedings before the Board following this decision, the Board has opted for purposes of administrative efficiency not to create a separate case number within OH-CDMS at this time. Should additional proceedings before the Board occur in these cases on remand to the Board, then the Board would do so at that time, as appropriate and relevant.
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[8] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] 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.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] 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 . . . .[13]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[14]

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*

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

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.[16]

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

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[17] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[18]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[19] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[20] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[21]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[22] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[23] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied

---

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

from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[24]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[25] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [26] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[27]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[28] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[29]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[30] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

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

[24] 68 Fed. Reg. at 27208.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[29] *Id.*
[30] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[31]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[32]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[33] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[34] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and

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

> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[35]

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

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[36]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[37]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[38] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a

[35] (Emphasis added.)
[36] (Emphasis added.)
[37] *Id.*
[38] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).

> practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[39]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[40] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[41] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[42] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[43] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[44] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[45] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[46] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[47]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[48] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[49] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[50] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before

---

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

the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[51] and that the regulation is procedurally invalid.[52]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[53] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[54] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[55] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[56] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[57] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[58] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[59] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

---

[51] *Id.* at 1162.
[52] *Id.* at 1163
[53] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[54] *Id.* at 884.
[55] *Id.* at 884.
[56] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[57] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[58] *Id.* at 886.
[59] *Id.*

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[60] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

III. Providers' Position

The Providers argue that CMS has been inconsistent with the treatment of days for Medicare inpatients who have exhausted their Part A benefits or whose days have otherwise not been paid (Part A exhausted and non-covered days). They note that, historically, these days were not counted in the Medicare fraction, but in the FY 2004 IPPS Proposed Rule, CMS proposed counting the days in the numerator of the Medicaid fraction for patients who were dually-eligible. The Providers also claim the FY 2004 IPPS Proposed Rule incorrectly stated CMS' policy was to include Part A exhausted and non-covered days in the Medicare/SSI fraction. The Providers note that CMS did not enact the 2004 rule proposal. However, the FY 2005 IPPS Final Rule finalized the opposite policy – that Part A exhausted and non-covered days would be counted in the Medicare fraction and excluded from the numerator of the Medicaid fraction. The Providers claim this is the opposite rule from what was proposed, and it also reversed a decades old policy. The Providers contend this new rule has had the effect of decreasing hospitals' DSH payments from FY 2005 forward because exhausted non-covered days are now categorically excluded from the Medicaid fraction's numerator and are only included in the Medicare/SSI fraction.[61]

The Providers claim that these days should be included in the numerator of the Medicaid fraction (for dually-eligible patients) and excluded from the Medicare fraction because these days relate to patients who were not "entitled to" Part A benefits "for such days" when the services were provided. They state that CMS' policy deserves no deference. CMS misstated both its current and proposed policies in its FY 2004 and 2005 rulemaking, failed to provide adequate notice and opportunity for comment, and has interpreted "entitled to benefits under [Medicare Part A]" for purposes of the DSH fractions in a manner inconsistent with the statute and precedent. They note that the decision in *Empire Health Foundation v. Azar* vacated the regulation at issue. Since the regulation was held to be invalid and is being reviewed by the Supreme Court, and because the Board lacks the authority to review the validity of a regulation, EJR is appropriate.[62]

IV. Board Decision

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

[60] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).
[61] EJR Request at 3.
[62] *Id.* at 5.

either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

A. Jurisdiction for Appeals of Cost Report Periods Beginning Prior to Jan. 1, 2016

Each of the three Providers have appealed a FYE prior to December 31, 2016.

1. Statutory and Regulatory Background

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[63] 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.[64]

On August 21, 2008, new regulations governing the Board became effective.[65] Among these new regulations was 42 C.F.R. § 405.1835(a)(1)(ii) which added the requirement for cost report periods ending on or after December 31, 2008 that providers who were self-disallowing specific items to do so by following the procedures for filing a cost report under protest.

This new regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[66] 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.[67]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which addresses dissatisfaction with Medicare Contractor determinations for cost report periods which end on or after December 31, 2008 but began before January 1, 2016, Under this Ruling, where the Board determines that the specific

---

[63] 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.).
[64] *Bethesda*, 108 S. Ct. at 1258-59.
[65] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[66] 201 F. Supp. 3d 131 (D.D.C. 2016).
[67] *Id.* at 142.

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) are no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

2. Jurisdiction over Case Nos. 17-2135GC(A) and 17-2135GC(B) and the Underlying Participants

The Board has determined that the Dual Eligible Part A Exhausted/MSP Days issues in the instant appeal is governed by CMS Ruling CMS-1727-R since the Providers are challenging the FY 2005 IPPS Final Rule, and Board review of the issues is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[68] The appeal was timely filed and no jurisdictional impediments for these issues have been identified. Based on the foregoing, the Board finds that it has jurisdiction for Case Nos. 17-2135GC(A) and 17-2135GC(B).

B. Board's Analysis of the Appealed Issues

42 C.F.R. § 405.1867 specifies that "[i]n exercising its authority to conduct proceedings under this subpart, the Board **must** *comply with* all the provisions of Title XVIII of the Act and *regulations issued thereunder* . . . ."[69] Consequently the Board finds that it is bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Provider, namely: (1) invalidating the amendments FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issues and calendar year under appeal in this case.

In making this finding, the Board notes that, as described above, the Providers maintained in their EJR request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated (either procedurally or substantively) and that, instead of reverting back to the prior policy of the Secretary under which such days were counted in neither fraction, those days should be counted in the numerator of the Medicaid fraction to the extent they involve patients who were also Medicaid eligible.

As evidenced by the 9th Circuit's decision in *Empire*, the invalidation of the DSH no-pay Part A days policy (as finalized in the FY 2005 IPPS Final Rule) does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that the 9th Circuit's decision in *Empire* only reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i) under which no-pay Part A days were counted in neither the Medicare fraction nor the Medicaid fraction.

---

[68] *See* 42 C.F.R. § 405.1835(a)(2).
[69] (Emphasis added.)

Moreover, it is clear that the situation in the instant case is not as simple as the one presented in *Allina Health Servs. v. Sebelius* ("*Allina*").[70] In *Allina*, the 9th Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in Allina stated: "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individua l is either eligible for Medicare Part A, or not)."[71]

In contrast, this case involves no-pay Part A days and the subset of no-pay Part A days associated with dual eligibles. It is clear that the *class of patients* who are dually eligible do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, with respect to this *patient class*, any days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction and included in the Medicaid fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits).[72] To this end, the Providers are asserting that only in *certain* ***no-pay*** Part A situations that involve a dual eligible beneficiary (*e.g.*, exhausted benefits and MSP) must the days associated with this class of patients be excluded from the SSI fraction and included in the Medicaid fraction.

Similarly, the class of patients who have Medicare Part A includes dual eligibles and that, with respect to this larger patient class, any days associated with them may not be excluded *in toto* (*i.e.*, it is undisputed that some Part A patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits). Significantly, under the Providers' desired interpretation of the DSH statute, any days associated with no-Pay Part A days for which the beneficiary was *not* Medicaid eligible (*i.e.*, the patient was not a dual eligible) would not be counted in either the Medicare or Medicaid fraction.

Accordingly, the Board disagrees with the Providers' assertion that exclusion of days associated with no-pay Part A situations where the underlying patient is a dual eligible *automatically* means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to: (1) the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*");[73] and (2) CMS Ruling 1498-R2, wherein multiple possible treatments of no-pay dual eligible days are discussed and wherein CMS reconfirms that its policy prior to October 1, 2004 was to exclude all no-pay Part A days from the Medicare and Medicaid fractions even where the underlying patient was also eligible for Medicaid, stating:

> Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the

[70] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[71] *Id.* (emphasis added).
[72] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[73] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients.

> patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 CFR 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098).[74]

Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[75] Thus, in the event the Supreme Court upholds the 9th Circuit's decision in *Empire*, the Providers would be arguing that the CMS' prior policy of excluding from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.

Accordingly, the Board continues to maintain that the Provider's legal argument for the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the Provider's legal argument for the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the subset of no-pay part A days that involve patients who are eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating the Provider's EJR request as a consolidated request involving two separate issues - Dual Eligible , Non-Covered or Exhausted Part A Days in both the SSI and Medicaid fractions.

C. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matters at issue for the subject year and that the Providers in Case Nos. 17-2135GC(A) and 17-2135GC(B) are entitled to a hearing before the Board;

---

[74] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.

[75] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater"*).

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

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

4) It is without the authority to decide the legal question in Case No. 17-2135GC(A) of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid and the legal question in Case No. 17-2135GC(B) of what policy should then apply, namely whether to exclude or include such no-pay Part A days which involve a dual eligible from the Medicaid fraction if all no-pay Part A days are excluded from the Medicare fraction.

Accordingly, the Board finds that the questions in Finding No. 4 properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' consolidated 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. Case Nos. 17-2135GC(A) and 17-2135GC(B) are now closed.

Board Members Participating

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

FOR THE BOARD:

5/13/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop B1-01-31
Baltimore, MD 21244-1850
410-786-2671

Via Electronic Delivery

Robert Roth, Esq.
Hooper, Lundy & Bookman, P.C.
401 9th Street, N.W., Suite 550
Washington, DC 20004

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

Linda Marsh, SEVP
AHMC Healthcare
500 East Main Street
Alhambra, CA 91801

Lorraine Frewert, Appeals Coordinator
Noridian Healthcare Solutions c/o
Cahaba Safeguard Administrators (J-E)
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Reconsideration of Surviving CY 2021 AHMC Standardized Amount CIRP Group***
AHMC Healthcare FFY 2021 Standardized Amount Base Rate Accuracy CIRP Group,
PRRB Case No. 21-0916GC (HLB Rep)

AHMC Healthcare FFY 2021 IPPS Understated Standardized Amount Payment Amount CIRP Group, PRRB Case No. 21-0435GC (QRS Rep)

QRS FFY 2021 IPPS Understated Standardized Payment Amount Optional Group
PRRB Case No. 21-0753G (QRS Rep)

Dear Mr. Roth, Mr. Ravindran, Ms. Marsh and Ms. Frewert:

On January 11, 2022, the Provider Reimbursement Review Board ("Board") issued a determination dismissing Case No. 21-0916GC as a duplicate of Case No. 21-0435GC because, among other things, it found the authorization letter for Quality Reimbursement Services, Inc. ("QRS") to be the most recent. In correspondence filed on January 26, 2022, Hooper, Lundy & Bookman, P.C. ("Hooper Lundy") requested a reconsideration of that determination. A brief background of the group cases, a summary of the prior Board determination, as well as the Board's ruling on the reconsideration request are set forth below.

Background of Case No. 21-0435GC

On January 5, 2021, QRS filed a CIRP group appeal for the FFY 2021 IPPS Understated Standardized Payment Amount issue for AHMC. The group contained 7 participants and included a global representation letter, dated September 18, 2020. The representation letter specified that QRS was "appointed as designated representative with respect to the Inpatient Prospective Payment System Understated Standardized Amount issue for the above referenced years" for an "Attached List" of providers which contained 7 AHMC providers. The group was fully formed on January 5, 2022 with those 7 providers.

Background of Case No. 21-0753G

On February 16, 2021, QRS filed an *optional* group appeal request for the FFY 2021 IPPS Understated Standardized Payment Amount Group. The optional group was formed with 32 participants. On February 16, 2021, QRS also directly added Alhambra Hospital Medical Center (Prov. No. 05-0281), a member of the AHMC organization) to the optional group.[1]

Background of Case No. 21-0916GC

On February 27, 2021, Hooper Lundy filed a CIRP group appeal for the FFY 2021 Standardized Amount Base Rate Accuracy issue for AHMC. The global representation letter included with the group appeal request, dated January 27, 2020, stated that Hooper Lundy "is hereby authorized to represent AHMC Healthcare, Inc., and its affiliated providers (Providers, ***as set forth in the attached list of Providers***, before the Provider Reimbursement Review Board with respect to a legal challenge to the . . . errors in the application of the 1981 cost reporting data that was used in 1983 to calculate the standardized amounts in the Medicare Inpatient Prospective Payment System (IPPS) payments . . . ."[2] The "attached list of Providers" contained 8 providers, including Alhambra Hospital Medical Center (Prov. No. 05-0281), the provider previously included in the QRS optional group under Case No. 21-0753G.

On March 9, 2021, Hooper Lundy added 2 additional AHMC hospitals: AHMC Seton Medical Center and AHMC Seton Medical Center Coastside. Both providers had been recently acquired, but Medicare provider numbers had not yet been issued. Therefore, the addition of the 2 providers could not be effectuated in the Office of Hearing Case & Document Management System ("OH CDMS") by the Representative and the request was filed as "other case correspondence."[3]

MAC Notification re: Duplications in Case Nos. 21-0435GC, 21-0916GC and 21-0753G

On April 19, 2021, the MAC filed correspondence in both CIRP groups in which it notified the Board of the *duplicate* CIRP group appeals and the duplication of Alhambra Hospital Medical Center (Prov. No. 05-0281) as a participant in the Hooper Lundy AHMC CIRP group, Case No. 21-0916GC, as well as in the QRS optional group, Case No. 21-0753G.

Board Determination dated January 11, 2022

After reviewing the facts in the 3 group cases, the Board found that all 3 groups were filed from the same final determination (the September 18, 2020 Federal Register Notice) and that both of the AHMC CIRP groups included representation letters signed by ***same*** AHMC executive. It also determined that Alhambra Hospital Medical Center (Prov. No. 05-0281) was a participant in an optional group, as well as a CIRP group for the same issue, based on a filing from the same final determination for the same FFY.

[1] As directed in the Board's January 11, 2022 determination, QRS subsequently withdrew the CIRP Provider from the optional group on January 31, 2022.
[2] (Emphasis added.)
[3] Ultimately, it was determined that both providers were operating under the same provider number so the Provider was identified as AHMC Seton Medical Center with the Medicare-assigned provider number of 05-0289.

Consequently, the Board took the following actions:

- AHMC Seton Medical Center (Prov. No. 05-0289) was dismissed from Case No. 21-0916GC because the Board found that Hooper Lundy was not authorized, on March 9, 2021, to file the direct add request for this AHMC Provider.[4]

- The Board advised that Case No. 21-0916GC would be closed as a duplicate of Case No. 21-0435GC, after transferring Alhambra Hospital Medical Center (Prov. No. 05-0281) to Case No. 21-0435GC.[5] *(This AHMC Provider had been omitted from the QRS CIRP group.)*

- QRS was directed to withdraw Alhambra Hospital Medical Center (Prov No. 05-0281) from its *optional* group under Case No. 21-0753G because it had already been included as a participant in the CIRP group under Case No. 21-0916GC.

- AHMC was ordered to execute a new letter of representation to confirm who would continue to represent AHMC for the Standardized Amount issue for FFY 2021 in the surviving group, Case No. 21-0435GC.

Request for Reconsideration dated January 26, 2022

On January 26, 2022, Hooper Lundy requested that the Board reconsider its dismissal of Case No. 21-0916GC as a duplicate of the QRS CIRP group appeal under Case No. 21-0435GC. Specifically, in its request for reconsideration, Hooper Lundy contends that:

> 1) A proper authorization of representative letter which included AHMC Seton Medical Center (Prov. No. 05-0289), was filed when it was directly added the Provider to the group on March 9, 2021.[6] Therefore, Hooper Lundy disagrees with the Board determination to dismiss AHMC Seton Medical Center from Case 21-0916GC.
>
> 2) The Board's determination retaining Case No. 21-0435GC as the surviving case (based on QRS having the most recent representation letter) is inaccurate. Hooper Lundy contends that the authorization letter (inclusive of all providers) that was signed and dated by AHMC Healthcare on March 1, 2021, and was filed with the March 9, 2021 Direct Add Request, superseded QRS' September 18, 2020 authorization.
>
> 3) The transfer of Alhambra Hospital Med Center (Prov. No. 05-0281) from the Hooper Lundy CIRP group to the QRS CIRP group should be reversed.

[4] The Board noted that the original global Representation Letter filed with Case No. 21-0916GC (dated 1/27/2021) authorized Hooper Lundy to represent only 8 providers and that list did ***not*** include AHMC Seton Medical Center.
[5] The closure notification for Case No. 21-0916GC was issued on January 18, 2022 after the transfer of Alhambra Hospital Medical Center (Prov. No. 05-0281) was effectuated in the Office of Hearings Case & Document Management System ("OH CDMS").
[6] An authorization of representative letter was included when the Provider(s) were directly added to the appeal on March 9, 2021 although, at the time, the Provider(s) had not been assigned a provider number.

4) Hooper Lundy did *not* withdraw AHMC Seton Medical Center Coastside from its group.[7]

Accordingly, Hooper Lundy requested that the Board:

- Recognize that, as of January 11, 2022, the revised authorization of representation letter signed and dated by AHMC Healthcare on March 1, 2021 appointing Hooper Lundy was actually the most recent authorization and superseded that of QRS;

- Reverse the closing of Case No. 21-0916GC and name it as the surviving CIRP group; including all 9 AHMC hospitals;[8] and

- Close the QRS CIRP group under Case No. 21-0435GC as a duplicate of Case No. 21-0916GC.

Board Ruling on Request for Reconsideration

The Board has reviewed the background of the groups and the AHMC Authorization letters for Representation of the FFY 2021 IPPS Understated Standardized Amount Payment Amount CIRP groups. The AHMC Authorization letters for Representation as submitted in the 2 CIRP groups are summarized below:

Case No	Rep Letter Dated	Rep Letter Filed on	Provider Nos. Included on Authorization
21-0435GC	9/18/2020	1/5/2021	05-0226, 05-0737, 05-0738, 05-0736, 05-0132, 05-0735, 05-0102
21-0916GC	1/27/2020	2/27/2021	05-0102, 05-0737, 05-0738, 05-0736, 05-0735, 05-0132, 05-0226, 05-0281
21-0916GC	3/1/2021	3/9/2021	05-0102, 05-0737, 05-0738, 05-0736, 05-0735, 05-0132, 05-0226, 05-0281 + AHMC Seton Med Center & AHMC Seton Med Center Coastside
21-0916GC	1/20/2022	1/26/2022	05-0102, 05-0132, 05-0226, 05-0281, 05-0735, 05-0736, 05-0737, 05-0738, 05-0289

Upon review, the Board agrees that, at the time of its January 11, 2022 determination on duplication of CIRP groups, Hooper Lundy did, in fact, have the most recent authorization letter and that such letter was inclusive of all 9 participants in the AHMC Healthcare System. Accordingly, the Board agrees to reverse its January 11, 2022 determination making QRS' Case No. 21-0435GC the surviving CIRP group for the AHMC Healthcare FFY 2021 IPPS Understated Standardized Amount Payment Amount issue and is reinstating Hooper Lundy's Case No. 21-0916GC.

[7] Hooper Lundy did acknowledge that AHMC Seton Medical Center Coastside does not have a separate provider number and operates under AHMC Seton Medical Center's provider number. Therefore, it should not be a separate hospital in the group and no further action is required with regard to this Provider as a participant in Case No. 21-0916GC.

[8] As noted, an updated authorization of representation letter dated January 20, 2022, appointing Hooper Lundy, has been submitted with the request for reconsideration.

Because the Board previously effectuated a transfer of Alhambra Hospital Medical Center (Prov. No. 05-0281) from Case No. 21-0916GC to 21-0435GC, the Provider will be transferred back to the newly reinstated group, Case No. 21-0916GC. The "group to group" transfer notification will be issued under separate cover, from Case No. 21-0435GC, shortly after the issuance of this determination. Upon the effectuation of the transfer of Alhambra Hospital Medical Center (Prov. No. 05-0281) from Case No. 21-0435GC to Case No. 21-0916GC, the QRS CIRP group will be then be closed.

Further, the Board hereby reinstates AHMC Seton Med Center (Prov. No. 05-0289 ("AHMC")) as a participant in the Hooper Lundy CIRP group under Case No. 21-0916GC. Upon further review, it has come to the Board's attention that the Group Representative filed two different representation letters for AHMC where the document title for one is identified in OH CDMS as the "Representation Letter Document" and the other is simply identified as "Other." The Board's dismissal was based on the "Representation Letter Document." Upon further review, the Board has identified the other representation letter filed as "Other" and finds that this representation letter dated March 1, 2021 (which was filed with the March 9, 2021 Direct Add Request) did include authorization for the Provider, even though its Medicare provider certification number had not yet been assigned.

After the effectuation of the transfer of Alhambra Hospital Medical Center (Prov. No. 05-0281) back from Case No. 21-0435GC and the reinstatement of HMC Seton Medical Center (Prov. No. 05-0289) in Case No. 21-0916GC, the surviving group under Case No. 21-0916GC will be considered to be fully formed. Therefore, a Group Completion Notice and Critical Due Dates notice will be issued in Case No. 21-0916GC under separate cover.

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

FOR THE BOARD:

5/17/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Dylan Chinea
Toyon Associates, Inc.
1800 Sutter St., Ste. 600
Concord, CA 94520-2546

RE: *EJR Determination*
15-2763GC – *Palomar Pomerado Health 2008 Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group*

Dear Mr. Chinea:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 29, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal. The decision of the Board is set forth below.

I. Issue in Dispute

This group was created after the Providers sought to transfer the issue in dispute from two individual appeals.[1] The Providers attached to their group appeal request, a copy of their individual appeal issue statements, which stated the issue in dispute, identically, as follows:

> The Provider disputes the SSI percentage developed by [the Centers for Medicare & Medicaid Services ("CMS")] and utilized by the [Medicare Administrative Contractor ("MAC")] in their updated calculation of Medicare DSH payment. On May 3, 2010 CMS published CMS Ruling 1498-R pertaining to three Medicare DSH issues, one of which requires the inclusion of Medicare Part A non-covered days (such as exhausted benefit days and Medicare secondary payer days) in the SSI ratio of the Medicare DSH payment calculation.
>
> The Provider contends CMS' new interpretation of including Medicare Dual Eligible Part A Days in the SSI ratio issued on March 16, 2012 is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the *Northeast Hospital* decision. The Secretary did not validly change her interpretation of the DSH calculation prior to FFY 2013, and because there is "no statute that authorizes the Secretary to promulgate retroactive rules

[1] Providers' Request to Establish CIRP Group Appeal (June 11, 2015).

> for DSH calculations," *id.,* the Secretary cannot impose her new interpretation on the DSH payment calculation challenged in this case. The Provider's position is supported by the federal district court decision in *Allina Health Services, et al, v. Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services* (Civil Action No. 10-1463 (RMC)). The Provider maintains the position all unpaid Medicare Dual Eligible Part A Days should be included in the Medicaid patient day ratio of the Medicare DSH payment calculation. The applicable Medicare regulations are 42 C.F.R. 412.106 and 42 C.F.R. 412.624.[2]

For Pomerado Hospital, the Provider indicates that the estimated Medicare reimbursement at issue is $102,666 based upon the exclusion of 192 Medicare Dual Eligible Part A Days from the SSI Ratio and inclusion of 192 additional Medicare Dual Eligible Part A Days in the Medicaid patient day ratio of the Medicare DSH payment calculation.[3]

For Palomar Medical Center, the Provider indicates the estimated Medicare reimbursement at issue is $447,225 based upon the exclusion of 1,045 Medicare Dual Eligible Part A Days from the SSI Ratio and inclusion of 1,045 additional Medicare Dual Eligible Part A Days in the Medicaid patient day ratio of the Medicare DSH payment calculation.[4]

In the Providers' request for EJR, they frame the legal question as follows. The Providers, who are within the Ninth Circuit's jurisdiction, request a determination from the Board whether, in light of the Ninth Circuit's decision in *Empire Health Foundation for Valley Hospital Center v. Azar,* 958 F.3d 873 (9th Cir. 2020) ("*Empire*"), it has the authority to instruct the MAC to recalculate the Providers' DSH payments by no longer treating days that are not entitled to Part A payment as being "entitled to benefits under Part A" for purposes of both the Medicare and Medicaid DSH fractions.[5] If the Board determines it lacks that authority, the Board should grant EJR.[6] If the Board believes it has that authority by virtue of the Ninth Circuit's decision, it should remand to the MAC with instructions to recalculate the Providers' DSH payments by no longer treating days that are not entitled to Part A payment as nonetheless being "entitled to benefits under Part A" consistent with the ruling in *Empire.*[7]

Thus, it is clear from the Providers' issue statements that the Medicare Dual Eligible Part A Days in the SSI ratio issue impacts ***both*** the Medicare/SSI fraction and the Medicaid fraction of the DSH payment calculation. When framing issues for adjustments involving multiple components, Board Rule 8.1 requires that "each contested component must be appealed as a separate issue and described as narrowly as possible." Further, the statute and regulations governing group appeals specifically note that a provider has a right to a Board hearing as part of

---

[2] *Id*. at 44, 70.
[3] *Id*. at 44.
[4] *Id*. at 70.
[5] Request for Expedited Judicial Review, 1 (Apr. 29, 2022) ("EJR Request").
[6] *Id*.
[7] *Id*. at 1-2.

a group appeal with other providers "***only if***. . . [t]he matter at issue in the group appeal involves a ***single*** quest of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group[.]"[8] Similarly, "[w]hen the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."[9] As discussed below in Section IV.B, the Board concludes that the Providers' challenge to the application of Dual Eligible , Non-Covered or Exhausted Part A Days in both the SSI and Medicaid fractions is two separate issues, even though they are identified in the Providers' appeal and EJR requests, and OH CDMS, as one combined issue. In this regard, the Board notes that it has historically required the formation of two separate groups for the Exhausted Part A Days issue as it relates to the SSI and Medicaid Fractions when the issue statement for the group request exclusion of no-pay Part A days from the SSI fraction and inclusion of the subset of those days involving dual eligible in the numerator of the Medicaid fraction.[10]

Since the Board has determined jurisdiction is proper for all participants for both issues (as discussed in Section IV.A below), and for the sake of judicial economy, the Board is hereby bifurcating this CIRP Group Appeal into the following cases, as reflected in the attached Schedules of Providers:

- 15-2763GC(A) – Palomar Pomerado Health 2008 Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group/SSI Fraction

- 15-2763GC(B) – Palomar Pomerado Health 2008 Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group/Medicaid fraction[11]

Accordingly, the Board is treating this EJR request as a consolidated EJR request cover both issues, as discussed below.

II. Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

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

[8] 42 C.F.R. § 405.1837(a)(2). *See also* 42 U.S.C. 1395oo(b) (noting that a group appeal is proper "***only if*** the matters in controversy involve a common question of fact or interpretation of law or regulations . . .").
[9] 42 C.F.R. § 405.1837(f)(2)(ii).
[10] The Board also takes administrative notice that, when processing EJR requests on these two issues, it is correcting any limited situations where the Board may have previously consolidated these two issues in error.
[11] As these cases have the same record up to this point and there will be no further proceedings before the Board following this decision, the Board has opted for purposes of administrative efficiency not to create a separate case number within OH-CDMS at this time. Should additional proceedings before the Board occur in these cases on remand to the Board, then the Board would do so at that time, as appropriate and relevant.

inpatient prospective payment system ("IPPS").[12] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[13]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[14] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[15]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[16] 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.[17] The DPP is defined as the sum of two fractions expressed as percentages.[18] 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 . . . .[19]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[20]

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

[12] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[13] *Id.*
[14] *See* 42 U.S.C. § 1395ww(d)(5).
[15] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[16] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[17] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[18] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[19] (Emphasis added.)
[20] 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.[21]

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.[22]

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

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[23] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[24]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[25] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[26] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[27]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[28] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare

---

[21] (Emphasis added.)
[22] 42 C.F.R. § 412.106(b)(4).
[23] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.* at 27207-27208.
[28] *Id.* at 27207-08.

contractors[29] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[30]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[31] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [32] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[33]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[34] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[35]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[36] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently *misstated* our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is

[29] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[30] 68 Fed. Reg. at 27208.
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[35] *Id.*
[36] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[37]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[38]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[39] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[40] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and

[37] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[38] *Id.* at 49099 (emphasis added).
[39] *Id.*
[40] *See id.* at 49099, 49246.

> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[41]

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

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[42]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[43]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[44] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a

[41] (Emphasis added.)
[42] (Emphasis added.)
[43] *Id.*
[44] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).

> practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[45]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[46] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[47] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[48] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[49] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[50] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[51] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[52] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[53]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[54] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[55] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[56] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before

---

[45] (Citations omitted and emphasis added.)
[46] 317 F. Supp. 3d 168 (D.D.C. 2018).
[47] *Id.* at 172.
[48] *Id.* at 190.
[49] *Id.* at 194.
[50] *See* 2019 WL 668282.
[51] 718 F.3d 914 (2013).
[52] 657 F.3d 1 (D.C. Cir. 2011).
[53] 718 F.3d at 920.
[54] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[55] *Id.* at 1141.
[56] *Id.*

the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[57] and that the regulation is procedurally invalid.[58]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[59] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[60] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[61] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[62] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[63] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[64] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[65] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

---

[57] *Id.* at 1162.
[58] *Id.* at 1163
[59] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[60] *Id.* at 884.
[61] *Id.* at 884.
[62] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[63] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[64] *Id.* at 886.
[65] *Id.*

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[66] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

III. Providers' Position

The Providers are challenging the inclusion of certain non-covered (Part A exhausted or Medicare secondary payor) patient days in the Medicare (or SSI) fraction.[67] The Providers believe that the Ninth Circuit's decision in *Empire* entirely vacates the Secretary's 2005 Rule, discussed above, on a nationwide basis and that, at a minimum, the *Empire* ruling is binding for hospital's in the Ninth Circuit as the Providers argue CMS has seemed to recognize.[68] The hospitals in this group appeal are within the Ninth Circuit's jurisdiction, and thus the Providers argue that that decision is binding and remains in effect until the Supreme Court determines otherwise because the government did not request a stay of the decision pending Supreme Court review.[69] The Providers argue that if the Board believes it is bound by the Ninth Circuit's decision, the Providers request that the Board remand this case to the MAC to recalculate all of the Providers' DSH payments consistent with the *Empire* ruling in which CMS' 2005 regulation was vacated and CMS' pre-2005 regulation under which only "covered" Part A days are treated as being "entitled to benefits under Part A" was reinstated.[70]

If instead, the Board believes it continues to be bound by CMS' 2005 regulation, and/or CMS Ruling 1498R, the Providers request that the Board grant EJR on this issue.[71]

IV. Decision of the Board

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

---

[66] *Bacerra v. Empire Health Fdtn*., No. 20-1312 (S. Ct. cert. granted July 2, 2021).
[67] EJR Request, at 1-3.
[68] *Id.* at 2-3, *citing* Pub. 100-09 Medicare Contractor Beneficiary and Provider Communications, Transmittal 11127 (Nov. 16, 2021) (calculating the 2019 SSI fractions for hospitals within the Ninth Circuit consistent with *Empire*); Transmittal 11276 (Feb. 24, 2022) (calculating the same for 2020).
[69] *Id.* at 1-3.
[70] *Id.*
[71] *Id.*

A. Jurisdiction for Appeals of Cost Report Periods Ending Prior to Dec. 31, 2008

The Providers in Case Nos. 14-2763GC(A) and 14-2763GC(B) have appealed cost reports with fiscal year ends ("FYEs") prior to December 31, 2008, namely, cost reports with FYEs of June 30, 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 an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen*.[72] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[73]

The Board has determined that the unpaid Medicare Dual Eligible Part A Days issues are governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. As such, since the Providers filed their cost reports in compliance with this regulation, they are not barred from claiming dissatisfaction with the amount of reimbursement allowed by the regulation and, in turn challenging that regulation as part of these appeals.

In addition, the Providers' documentation for both Case Nos. 14-2763GC(A) and 14-2763GC(B) shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[74] The appeals was timely filed and no jurisdictional impediments for these issues have been identified. Based on the foregoing, the Board finds that it has jurisdiction to conduct a hearing on the specific matter at issue in Case Nos. 14-2763GC(A) and 14-2763GC(B).

B. Board's Analysis of the Appealed Issue

First, the Providers assert that the *Empire* ruling is binding for hospitals in the Ninth Circuit as the Providers argue that CMS has seemingly recognized that fact in CMS Transmittal No. 11127, which addresses the SSI/Medicare Beneficiary Data to be used in the calculation of DSH adjustments.[75] That transmittal directs Medicare Contractors to include only "covered days" in the SSI ratio, and provides as follows: "For IPPS hospitals in the Ninth Circuit's jurisdiction (Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon and Washington), these

---

[72] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[73] *Bethesda at 1258-59*.
[74] *See* 42 C.F.R. § 405.1837(a)(3).
[75] Transmittal No. 11127 (Nov. 16, 2021), and related MLN Matters Article No. MM12516, are available online at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r11127com.

ratios include only "covered days" to reflect the decision of the 9th Circuit in Empire Health Foundation v. Azar (currently pending before the Supreme Court), to preliminarily settle cost reports."[76] However, that transmittal and the transmittal issued the following year to which the Providers cite, apply only for FY 2019 and FY 2020, respectively.[77] Importantly, the purpose of calculating those cost reports pursuant to *Empire* is to "preliminarily settle cost reports," and the transmittal notes that the Ninth Circuit's decision is currently pending before the Supreme Court. The cost reports at issue in this appeal have FYEs of June 30, 2008, and thus those transmittals are not applicable to this appeal.

Further, 42 C.F.R. § 405.1867 specifies that "[i]n exercising its authority to conduct proceedings under this subpart, the Board **must** *comply with* all the provisions of Title XVIII of the Act and *regulations issued thereunder* . . . ."[78] Here the Secretary has not yet acquiesced to the Ninth Circuit's decision in *Empire* and has not otherwise retracted or revised the regulation at issue. Consequently, the Board finds that it continues to be bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Provider, namely: (1) invalidating the amendments FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issues and calendar year under appeal in this case.

In making this finding, the Board notes that, as described above, the Providers maintained in their EJR Request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated, and such days should instead be counted in the patient days ratio of the Medicaid fraction (to the extent the days involve a dual eligible), and that this is consistent with the *Empire* ruling. However, as evidenced by the Ninth Circuit's decision in *Empire,* the invalidation of the DSH no-pay Part A days policy (as finalized in the FY 2005 IPPS Final Rule) does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that the Ninth Circuit's decision in *Empire* only reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i) under which no-pay Part A days were counted in neither the Medicare fraction nor the Medicaid fraction.

Moreover, it is clear that the situation in the instant case is not as simple as the one presented in *Allina Health Services v. Sebelius* ("*Allina*").[79] In *Allina*, the Ninth Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in *Allina* stated: "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[80]

---

[76] *Id.*
[77] *See id.*
[78] (Emphasis added.)
[79] 746 F.3d 1102, 1108 (D.D. Cir. 2014).
[80] *Id.* (emphasis added).

In contrast, this case involves no-pay Part A days and the subset of no-pay Part A days associated with dual eligibles. It is clear that the *class of patients* who are dually eligible do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, with respect to this *patient class*, any days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction and included in the Medicaid fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits).[81] To this end, the Providers are asserting that only in *certain* ***no-pay*** Part A situations that involve a dual eligible beneficiary (*e.g.*, exhausted benefits and MSP) must the days associated with this class of patients be excluded from the SSI fraction and included in the Medicaid fraction.

Similarly, the class of patients who have Medicare Part A includes dual eligibles and that, with respect to this larger patient class, any days associated with them may not be excluded *in toto* (*i.e.*, it is undisputed that some Part A patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits). Significantly, under the Providers' desired interpretation of the DSH statute, any days associated with no-Pay Part A days for which the beneficiary was *not* Medicaid eligible (*i.e.*, the patient was not a dual eligible) would not be counted in either the Medicare or Medicaid fraction.

Accordingly, the Board disagrees with the Providers' position that exclusion of days associated with no-pay Part A situations where the underlying patient is a dual eligible *automatically* means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to: (1) the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*");[82] and (2) CMS Ruling 1498-R, wherein multiple possible treatments of no-pay dual eligible days are discussed and wherein CMS reconfirms that its policy prior to October 1, 2004 was to exclude all no-pay Part A days from the Medicare and Medicaid fractions even where the underlying patient was also eligible for Medicaid, stating:

> Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI Fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 C.F.R. 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit

[81] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[82] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients.

> inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changed to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098).[83]

Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Medical Center v. Blue Cross Blue Shield Association* ("*Edgewater*").[84] Thus, in the event the Supreme Court upholds the Ninth Circuit's decision in *Empire,* the Providers would be arguing that CMS' prior policy of excluding from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.

Accordingly, the Board continues to maintain that the Provider's legal argument for the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the Provider's legal argument for the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the subset of no-pay part A days that involve patients who are eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating the Providers' EJR Request as a consolidated request involving two separate issues – Dual Eligible, Non-Covered or Exhausted Part A Days in both the SSI and Medicaid fractions.

C. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter at issue for the subject year and that the Providers in Case Nos. 15-2763GC(A) and 15-2763GC(B) are entitled to a hearing before the Board;

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

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

4) It is without authority to decide the legal question in Case No. 15-2763GC(A) of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid and the legal question in Case No. 15-2763GC(B) of what policy should then apply, namely

---

[83] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.

[84] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater"*).

whether to exclude or include such no-pay Part A days which involve a dual eligible from the Medicaid fraction if all no-pay Part A days are excluded from the Medicare fraction.

Accordingly, the Board finds that the questions in Finding 4 properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and grants the Providers' consolidated request for EJR for the issues and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. As there are no issues remaining in this appeal, the Board hereby closes it and removes it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

5/25/2022

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson C. Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Byron Lamprecht
WPS Government Health Administrators
2525 N 117th Ave., Ste. 200
Omaha, NE 68164

RE: ***Jurisdiction Determination***
QRS Empire Health 2005 SSI Part C Days CIRP Group
Case No. 17-0555GC

Dear Messrs. Ravindran and Lamprecht:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced common issue related party ("CIRP") group case in response to the January 16, 2020 Administrator's Order remanding the appeal back to the Board pursuant to the Minute Order of U.S. District Court for the District of Columbia ("District Court") granting the parties' Joint Motion for Remand ("Joint Motion"). The Board's decision is set forth below.

I. Background

Case No. 17-0555GC was established on November 30, 2016. Later, an EJR request was filed on March 20, 2019, for a number of group cases, including Case No. 17-0555GC, appealing the DSH Part C Days issue. On April 12, 2019, the Board issued a decision granting EJR for the substantive issue, but excluded certain providers which had jurisdictional impediments in their respective cases. This included two (2) providers in the instant case which were dismissed by the Board because their SSI percentages reflected a change of 0.0 on their cost reports, and they were appealing from Revised NPRs.[1] These two Providers were:

1. Deaconess Medical Center ("Deaconess") (Prov. No. 50-0044) for FYE 12/31/2007 ("FY 2007"); and
2. Valley Hospital Medical Center ("Valley Hospital") (Prov. No. 50-0119) for FYE 12/31/2006 ("FY 2006").[2]

Deaconess and Valley Hospital appealed the Board's decision to federal court, and eventually a Joint Motion for Remand[3] was filed together with the Secretary. The Joint Motion explained that the providers were appealing the Part C Days issue in the current case, but had both appealed

[1] RNPR dated (3/22/2017).
[2] RNPR dated (3/22/2017).
[3] Joint Motion for Remand of Plaintiffs' Medicare Reimbursement Claims and Dismissal (Oct. 15, 2019) ("Joint Motion").

from their original NPRs in earlier cases.[4] Those appeals were remanded to the Medicare Contractor by the Board on October 28, 2015, pursuant to CMS Ruling 1498-R.[5] The revised NPRs that were later issued pursuant to that Board remand are the same revised NPRs which were appealed in the instant case (Case No. 17-0555GC).[6] The most pertinent portion of the Joint Motion relates to the parties' agreement on jurisdiction:

> 8. After reviewing the Complaint and the Administrative Record, and in light of *Empire Health Foundation v. Burwell*, 209 F. Supp. 3d 261 (D.D.C. 2016), the Secretary has concluded that the Board erred in dismissing the Hospitals from the Part C Days group appeal, and that the Hospitals' appeal of their respective initial NPRs meets all the requirements for Board jurisdiction. The Hospitals timely appealed the Part C Days issue from their respective initial NPRs, and the corrected NPRs resulting from the CMS 1498-R remand did nothing to extinguish those appeal rights.

While the Joint Motion included a proposed order, the District Court instead granted the Joint Motion via a brief Minute Order on October 22, 2019.[7] On December 18, 2019, the Administrator signed a Remand Order for the Board to "take actions consistent with the Joint Motion to Remand and the Court Order in this case[.]"[8] This Order was delivered to the Board on January 16, 2020.

On January 14, 2021, the Board issued a Request for Additional Information ("RFI") to the parties. The Board specifically requested that the parties "file with the Board comments or any other relevant information to supplement the record relative to the District Court's Minute Order '[g]ranting the Parties' Joint Motion to Remand' and the Administrator's Order that the 'Board shall take actions consistent with the Joint Motion to Remand and the Court Order in this case'" and further asked the parties to discuss two points:

> (1) Show cause as to why the remand of Deaconess for FY 2007, based on Deaconess's appeal of the March 22, 2017 RNPR for FY 2007, is not now moot due to the facts that: (a) Deaconess is a participant in a separate Empire CIRP group for the ***same*** issue and year under Case No. 10-1170GC based on Deaconess's earlier appeal of its original NPR for FY 2007; and (b) the Board granted EJR in Case No. 10-1170GC and Deaconess FY 2007 is one of the remaining

---

[4] *Id.* at ¶¶ 1-2. Both initial NPR appeals were ultimately transferred to PRRB Case Nos. 09-2071GC. *See* Response to PRRB's Request for Information at 1-2 & Exs. 1-2 (Mar. 10, 2021) ("Provider's Response to RFI").
[5] *Id.* at 2 & Ex. 3.
[6] *Id.* at 3; Joint Motion at ¶¶ 3, 5-6.
[7] Response to Board RFI, Ex. C-2 (Mar. 15, 2021) ("MAC's Response to RFI"). The full text of the Minute Order reads:

> MINUTE ORDER GRANTING the Parties' Joint Motion to Remand. The Court ORDERS that this matter shall be dismissed. So ORDERED by Judge James E. Boasberg on 10/22/2019 (lcjeb3) (Entered: 10/22/2019)

[8] *Id.* at Ex. C-3. The only other directive in this order was that the decision of the Board is subject to 42 C.F.R. § 405.1875.

> participants in that group for which EJR was granted. In making the request, the Board took administrative notice that, in *Allina Health Servs. v. Sebelius* ("*Allina*"), the D.C. Circuit specifically found that Part C days must be included in either the Medicare or Medicaid fraction: "[T]he statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[9]
>
> (2) What effect CMS Ruling 1739-R (issued on August 17, 2020) might have if the Board finds it has jurisdiction over either provider in the instant appeal and, in particular, whether this Ruling would require the Board to remand the Part C days issue as part of the January 2020 Administrator's Remand.

The Board also took administrative notice of several pertinent regulations, CMS Rulings, Board Rules, court cases, and previous Board cases, and invited the parties to consider them, as relevant and appropriate, in responding to the RFI.

A. Providers' Response to RFI

The Providers filed several responses to the RFI on March 10, 2021 (146 pages long), March 24, 2021 (8 pages long), and June 1, 2021 (59 pages long). In its March 10, 2021 filing, the Providers recognize that "The appeal in this case involves a long and complicated factual history."

The Providers argue that Deaconess's appeal in the instant case for the DSH Part C days issue was *not* mooted by the relief granted in Case No. 10-1172GC relative to the DSH Part C days issue. The Providers claim that, since Case Nos. 10-1172GC and 17-0555GC were resolved via the same Board decision, and that in each case Deaconess received a different jurisdictional finding over the same time period, the two cases must involve different issues. Specifically, the Providers claim that Case No. 10-1172GC involved whether Part C days should be included in the *Medicaid* fraction, and Case No. 17-0555GC involved whether they should be included in the *Medicare* fraction.[10] Providers further assert that, even if the D.C. Circuit held in *Allina* that Part C days must be included in one fraction or the other, the Providers claim that Board Rules 8 and 13 require these two issues be appealed separately.[11] They also argue that *Allina* is not controlling since these two providers are located in the 9th Circuit, and that the Board has "held that ***dual eligible*** days may be excluded from both fractions" and that the two issues should be litigated separately.[12] Finally, the Providers contend that the District Court order "explicitly requires the Board to exercise jurisdiction over the Deaconess Medicare fraction appeal, and either grant EJR or issue a decision on the merits."[13]

---

[9] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[10] Provider's Response to RFI at 6.
[11] *Id.* at 7-8 (citing *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1107-09 (D.C. Cir. 2014).
[12] *Id.* at 8 (quoting PRRB Dec. 2018-D43 (July 5, 2018)) (emphasis added).
[13] *Id.* at 8-9.

With regard to the applicability of CMS Ruling 1739-R, the Providers note that a remand will not result in the Medicare Contractor applying a different Medicaid fraction, similar to when their cases were remanded pursuant to CMS Ruling 1498-R. As such, a remand would not serve any real purpose.[14] Furthermore, since the Providers maintain that a statute requires specific treatment of Part C days, they imply that any further rulemaking contrary to this interpretation would be unlawful.[15] Perhaps more importantly, the Providers claim their appeals here do not fall within the scope of 1739-R, which applies to appeals claiming the treatment of Part C days was invalid due to insufficient notice-and-comment rulemaking. The Providers insist they are not challenging the Secretary's failure to undertake notice-and-comment rulemaking, but rather failure to adopt policies based on the plain language of the governing statute.[16] They also claim that remanding pursuant to 1739-R is contrary to the district court's remand order which "explicitly requires the Board to exercise jurisdiction over [the] Part C claims, and to either: (a) authorize EJR or (b) issue a hearing decision on the merits."[17] Finally, the Providers argue that 1739-R itself is invalid for several reasons, although they "recognize that the Board is not empowered to invalidate" the ruling.[18]

With regard to the additional authorities which the Board invited the parties to comment on "as relevant and appropriate," the Providers take issue with this approach not being more specific and claim many of the items are not appropriate for this remand. Instead, rather than inquire as to jurisdictional matters or whether certain policies were complied with, they argue that "the Board's obligation at this stage is limited to the specific terms of the remand order, i.e., exercise jurisdiction and either grant EJR or conduct a hearing on the merits."[19] With regard to Board Rule 4.6 (no duplicate filings), the Providers request the Board identify how this rule may have been violated, and that "[i]n any event, the time for asserting this argument has passed . . . the district court's remand order is unequivocal. The Board must exercise jurisdiction and either (a) grant EJR or (b) conduct a hearing on the merits."[20]

B. Medicare Contractor's Response to RFI

On March 15, 2021, the Medicare Contractor filed a response to the RFI (92 pages long). It directs the Board's attention to four developments related to the district court's remand. First, the Supreme Court decided *Allina* in 2019.[21] Second, in response to *Allina*, the Administrator of CMS issued CMS Ruling 1739-R, which requires certain Part C day appeals be remanded to the appropriate Medicare Contractor for implementation of the forthcoming new final rule. Third, it states that another district court remand,[22] where ninety-three (93) lawsuits were remanded for re-examination of the plaintiffs' Part C days in light of *Allina*. Finally, the Medicare Contractor

[14] *Id.* at 9-10.
[15] *Id.* at 10-11.
[16] *Id.* at 11.
[17] *Id.* at 11-12.
[18] *Id.* at 12-21.
[19] *Id.* at 23.
[20] *Id.* at 25-26.
[21] *Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019).
[22] *In re: Allina II-Type DSH Adjustment Cases*, Misc. Action No. 19-mc-190 (D.D.C. Nov. 4, 2019) (Copy at Ex. C-5).

notes that one of the 93 cases remanded was PRRB Case 10-1172GC, which concerns the same issue and fiscal year for Deaconess as the instant case.[23] The Medicare Contractor also makes a confusing and seemingly contradictory argument that Deaconess and Valley Hospital's revised NPR appeals were excluded from that same remand, and thus are still pending within an active federal case.[24]

With regard to the impact of 1739-R on the instant case's remand instructions, the Medicare Contractor also asserts that the district court "remanded the matter to the Secretary with instructions for the Board to exercise jurisdiction over the hospitals' appeals of their initial NPRs, and issue either an EJR decision or a hearing decision."[25] The Medicare Contractor acknowledges that 1739-R generally requires the Board remand certain jurisdictionally proper Part C days appeals for the Medicare contractors to apply the forthcoming final rule implementing *Allina*. It claims, however, that the district court's remand order "supersedes" the CMS ruling "in the hierarchy of legal authorities" and that the order "instructed the Board to issue either an EJR decision or a hearing decision."[26] The Medicare Contractor has suggested the Board issue a hearing decision, noting that, based on *Allina*, the Secretary's Part C days policy is unlawful because it was not promulgated with the notice-and-comment rulemaking requirements of 42 U.S.C. § 1395hh.[27] Then, the Board's remedy in its hearing decision should be to remand to the Medicare contractors to apply the forthcoming final rule implementing *Allina*.[28] It argues that this approach satisfies both the district court's remand order and the mandates of 1739-R.

C. Providers' Reply to Medicare Contractor's Response to RFI

The Providers also filed a letter in reply to the Medicare Contractor's Response to RFI on March 24, 2021. They begin with an argument as to why the Medicare Act is clear that Part C days should be excluded from the Medicare fraction.[29] Second, the Providers address the Medicare Contractor's arguments related to Deaconess' appeal being moot. They claim that any other remand orders cited by the Medicare Contractor specifically excluded Deaconess' appeal from the instant case (Case No. 17-0555GC). If two remand orders did overlap, the Providers claim that the Board's action in the instant case would resolve any overlapping remand instructions (assuming the Board asserts jurisdiction).[30] They conclude by stating, again, that "the express terms of the Court's remand order [direct the Board] to exercise jurisdiction over [the] appeal, and either grant EJR or issue a hearing decision on the merits."[31]

---

[23] MAC's Response to RFI at 2-4.
[24] *Id.* at 5-6.
[25] *Id.* at 7 (citing Proposed Order accompanying the Joint Motion).
[26] *Id.*
[27] *Id.* (citing *Azar v. Allina Health Servs.*, 139 S.Ct. at 1810-17).
[28] *Id.* at 7-8.
[29] Reply at 2-5.
[30] *Id.* at 6-7.
[31] *Id.* at 7-8.

D. Providers' Supplemental Response to PRRB's RFI

In their third response to the Board's RFI, the Providers explain that the MAC suggested that the Board issue a hearing decision on the merits and remand the Providers back to the MAC pursuant to CMS Ruling 1739-R. The Providers claim that this argument is not valid because CMS Ruling 1739-R is not applicable to this case.[32] Further, the Providers argue that a remand to the MAC after a decision on the merits would be incompatible with the Secretary's regulations because a decision on the merits is a final agency action, and providers have a right to immediate judicial review.[33]

II. Analysis and Decision of the Board

In their Joint Motion for Remand in District Court, the parties sought the following relief:

- For the "Court to remand the Hospitals' Medicare reimbursement claims to the Secretary for further proceedings before the [Board]."[34]
- "that this matter be remanded to the Secretary for review and decision by the Board regarding [the Hospitals' Part C Days issue,]"[35]
- that the court "remand this matter to the Secretary for further proceedings before the PRRB and the Administrator of CMS[,]"[36]
- For "dismissal of this action",[37]
- That "the Court retain jurisdiction solely for the purpose of enforcing the attached remand order[,]"[38] and
- That "the Court enter an order remanding the matter to the Secretary for further administrative proceedings before the PRRB and the Administrator of CMS and dismissing this action."[39]

As support for why these requests should be granted by the District Court, the parties included several stipulated facts in the Joint Motion. In this regard, as previously noted, ¶ 8 of the Joint Motion states that "the Secretary has concluded that the Board erred in dismissing the Hospitals from the Part C Days group appeal, and that the Hospitals' appeal of their respective initial NPRs meets all the requirements for Board jurisdiction" and that "[t]he Hospitals timely appealed the Part C Days issue from their respective initial NPRs, and the corrected NPRs resulting from the CMS 1498-R remand did nothing to extinguish those appeal rights."

---

[32] Providers' Supplemental Response to PRRB's RFI at 1 (June 1, 2021).
[33] *Id.* at 2 (citing 42 C.F.R. § 405.1877(a)(3)(i) (incorporating § 405.1875(a)(2)(i) through (a)(2)(iii)).
[34] Joint Motion for Remand at 1.
[35] *Id.* at ¶ 9.
[36] *Id.*
[37] *Id.* at 4.
[38] *Id.*
[39] *Id.*

Notwithstanding this stipulation, the Joint Motion itself only requested the District Court remand the case for additional administrative proceedings, and the Minute Order simply granted the Joint Motion for Remand and dismissed the case.[40] The Administrator's subsequent order required the Board to "take actions consistent with the Joint Motion to Remand and the Court Order in this case[.]"[41]

Thus, contrary to the Providers' assertion, the Court's remand order did ***not*** expressly "direct[] the Board 'to assume jurisdiction over the Hospitals' claims' in Case No. 17-0555GC."[42] The Board recognizes that the 2-page ***proposed*** order attached to the Joint Motion stated, in part:

> IT IS FURTHER ORDERED that on remand, the Secretary shall vacate the PRRB's April 12, 2019 jurisdictional dismissal decision in that group appeal only as it relates to Valley Hospital Medical Center and Deaconess Medical Center for their FYEs December 31, 2006 and 2007, respectively, ***and direct the PRRB to assume jurisdiction over the Hospitals' claims*** regarding the proper treatment of Part C days in the calculation of their DSH payment adjustments for those FYEs, and issue an expedited judicial review decision or a hearing decision on such claims. The PRRB's decision on remand shall be subject to review by the Administrator of the Centers for Medicare & Medicaid Services, and the final agency decision on remand shall be subject to judicial review in accordance with 42 U.S.C. § 1395oo(f)(1).

However, the District Court did not execute the proposed order but rather entered a "minute order granting the Parties' Joint Motion to Remand" and "order[ed] that this matter shall be dismissed."[43] 42 C.F.R. § 405.1877(g) addresses remand by a court and Paragraph 2 provides the following "Procedures":

> (i) Upon receiving notification of a court remand order, the Administrator must prepare an appropriate remand order and, if applicable, file the order in any Board appeal at issue in the civil action.
>
> (ii) The Administrator's remand order must -
>
> (A) Describe the specific requirements of the court's remand order;

[40] Exhibit C-2.
[41] Exhibit C-3.
[42] Provider's Supplemental Response at 7 (Mar. 23, 2021).
[43] Even it had been executed by the District Court, the proposed order would not have "direct[ed] the Board to assume jurisdiction" but rather would have ordered the Administrator to direct the Board to assume jurisdiction

> (B) Require compliance with those requirements by the pertinent component of HHS or CMS or by the contractor, as applicable; and
>
> (C) Remand the matter to the appropriate entity for further action.

Here, the Administrator's Remand Order simply "order[ed] that the [Board] shall take actions consistent with the Joint Motion to Remand and the Court Order in this case." Accordingly, the Board finds that there is no express directive that the Board assume jurisdiction.

As set forth below, the Board respectfully finds that it remains appropriate to dismiss both Valley for FY 2006 and Deaconess for FY 2007. Further, to the extent the Administrator or the reviewing District Court finds that the Board erred in dismissing Valley for FY 2006 and Deaconess for FY 2007, then the Board would remand the relevant Provider(s) pursuant to CMS Ruling 1727-R.

A. Dismissal of Valley for FY 2006 and Deaconess for FY 2007

1. Dismissal of Valley FY 2006

Pursuant to 42 C.F.R. § 405.1840(a) and Board Rule 4.1, the Board has an obligation to review jurisdiction and may review jurisdiction at any point during an appeal. The Board's jurisdictional decision to dismiss Valley FY 2006 from Case No. 17-0555GC was vacated and the Board was directed to take actions consistent with the Joint Motion and the District Court's remand order. The whole litigation around Valley FY 2006 stems from the allegation of the Group Representative, Quality Reimbursement Services ("QRS"), that the Board prematurely closed Case No. 09-2071GC because there were allegedly other issues remaining that group, notwithstanding the directive in 42 C.F.R. 405.1837(a)(1) that the matter at issue in the group appeal may only involve "a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." The Board disagreed that there were any other additional issues in the group appeal and, as a consequence, never reviewed whether each of the participants in Case No. 09-2071GC had properly appealed and transferred the other issues alleged to be in Case No. 09-2071GC. Upon review of that issue, the Board respectfully maintains that dismissal of Valley FY 2006 from Case No. 17-0555GC is appropriate.

The Providers, in their March 10, 2021 response to the Board's RFI, alleged that "On July 17, 2009, Valley Hospital *transferred* its challenge to the inclusion of ***Part C days*** in the Medicare fraction *into Group Appeal No. 09-2071GC*. Ex. 1."[44] The referenced "Exhibit 1" to support that statement consists of 10 pages as follows:

- Pages 1 to 3 — The group appeal request form dated July 17, 2009 that was used to establish Case No. 09-2071GC. This form references Tab 1 which showed the provider used to create the group and Tab 2 for the group issue statement. The third page of the form includes certifications signed on July 21, 2009.

[44] (Emphasis added.)

- Page 4 — The Representative Letter dated June 15, 2009 showing that Empire Health had appointed QRS as its designated representative for Valley Hospital for FY 2006.
- Pages 5 to 7 — The group issue statement filed for Case No. 09-2071GC that was attached to the group appeal request form behind Tab 2.
- Pages 8-10 — The transfer request form dated July 14, 2009 for Valley wherein it requests transfer from Case No. 09-0109 to this group being established. In other words, it was the provider behind Tab 1 of the group appeal request. The third page of the form includes certifications signed on July 14 and 16, 2009.

While QRS did not label Exhibit 1, it is clear that the exhibit was intended to represent the packet that QRS filed to establish Case No. 09-2071GC (*i.e.*, the group appeal request and the transfer of the requisite initial participant in that group). However, upon review of its files, the Board notes that *Exhibit 1 is an* ***incomplete*** *document* and only includes a portion of the packet that QRS filed to establish Case No 09-2071GC. In fact, upon review the *critical* portion of that document was left out – namely Valley's individual appeal request for FY 2006 that established Case No. 09-0109. This appeal request is critical because Valley could *only* transfer into Case No. 09-2071GC what it had appealed as part of its individual appeal under Case No. 09-0109 (*i.e.*, it could not use a transfer request to add issues to its appeal[45]). In this regard, the Board further notes that QRS included the original appeal request for Deaconess FY 2007 as Exhibit 2 to its March 10, 2021 Response to RFI, but it failed to include the original appeal request for Valley FY 2006 in any of the exhibits that it attached to its March 10, 2021 Response to RFI.

Under Board Rule 12.5 (July 1, 2009), "one Provider may initiate a CIRP group," in other words in order to establish a CIRP group there must be at least one initial participant. For Case No. 09-2071GC, there was only ***one*** initial participant and that initial participant was Valley for FY 2006. The packet that QRS filed to establish Case No. 09-2071GC was 31 pages long (as opposed to the 10 pages put forward by QRS at Exhibit 1 to the March 10, 2021 Response to RFI). As previously noted, QRS failed to include the original appeal request that Valley filed to establish Case No. 09-0109 for FY 2006 and from which Valley transferred to be the founding participant in 09-2071GC. A review of that document establishes that, *contrary to the Providers' assertion*, Valley ***never*** appealed the DSH Part C issue (whether relating to the Medicare or Medicaid fraction) from its original NPR and, as such, could ***never*** have transferred the DSH Part C days issue from Case No. 09-0109 to Case No. 09-2071GC. The Board has included this group appeal packet that QRS filed to establish Case No. 09-w071GC as Appendix A to this decision.

First, per the July 14, 2009 transfer request, Valley transferred the following issue to Case No. 09-2071GC:

> Whether the SSI percentage used in the Medicare DSH calculation by the Intermediary accurately and correctly accounts for all

[45] *See infra* note 55.

> patient days that must be included in the numerator and denominator of the SSI calculation.[46]

Review of Valley's original appeal request filed for FY 2006 (as attached to the group appeal request for Case No. 09-2071GC) confirms that the issue transferred from the individual appeal was Issue 1 which reads, in its entirety, as follows:

> **Issue 1: Disproportionate Share Payment/Supplemental Security Income Percentage**
>
> **Description of the Issue**
>
> Whether the [Intermediary] used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation.
>
> Audit Adjustment No.: 14, 18 *See* Tab 4.
> Estimated Reimbursement Amount: $21,267. *See* Tab 5.
>
> **Statement of Legal Basis**
>
> The Provider contends that the Intermediary did not determine Medicare DSH reimbursement in accordance with the statutory instructions at 42 U.S.C. 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the Intermediary's calculation of the computation of the DSH patient percentage set forth at 42 C.F.R. 412.106(b)(2)(i) of the Secretary's regulations. The Provider contends that the SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed. The SSI percentages computed by CMS for the Provider did not include all of these eligible SSI recipients for the following reasons:
>
> **SSI Sub Issue 1A – Availability of MEDPAR and SSA Records**
>
> A system of records entitled Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009 was published in the Federal Register on August 18, 2000. *See* 65 Fed. Reg. 50,548 (2000). This system of records was purported to establish a system to collect and disseminate the information necessary "to recalculate Supplemental Security Income ratios for hospitals that are paid under the [Prospective Payment System] and serve a disproportionate share

[46] Appendix A at Bates No. 00129. Note the record for Case No. 09-2071GC was Bates labeled by the CMS Office of the Attorney Advisor ("OAA") when that case went up on appeal and, as such, the document at Appendix A reflects that Bates labeling by OAA upon its return to the Board.

of low-income patients." *Id*. This data is a key component in determining whether affected hospitals may be entitled to increased reimbursement under Part A of the Medicare programs. However, the regulations impose restrictive conditions that do not permit the Provider to obtain and reconcile the SSI data maintained by CMS.

SSI Sub Issue 1B – Denominator of SSI Percentage – Total Days vs. Covered Days

The Provider contends that the SSI percentages published by CMS for Federal Fiscal Year Ending September 30, 2006, were incorrectly computed. CMS divided the number of SSI days by the total number of Medicare patient days. In the past CMS has always divided the number of SSI days by the covered number of Medicare Part A days. The total number of Medicare patient days includes Part B patient days and other non-covered days of service that should have been excluded from the denominator of the SSI percentage calculation. This error resulted in understated SSI percentages.

SSI Sub Issue 1C – Numerator & Denominator of SSI Percentage – Paid Days vs. Eligible Days

From the inception of the DSH adjustment in 1986, CMS stated that the SSI fraction would include days paid by Medicare, consistent with CMS' original policy regarding composition of the Medicaid fraction before issuance of HCFA Ruling 97-2. *See, e.g.*, 51 Fed. Reg. 31454, 31460 (Sep. 3, 1986). In defending its original policy concerning the Medicaid fraction, CMS represented to several federal courts that the Medicare/SSI fraction counts only Medicare paid days. *See, e.g., Legacy Emanuel Hospital & Health center v. Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996).

While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, Intermediaries have taken the position that the denominator of the SSI fraction should include "eligible" Medicare Part A days. Furthermore Intermediaries have argued that "eligible" days may include days that were not paid by Medicare.

On April 28, 2003 Pat Cribbs, a team leader for the database analysis section at the Social Security Administration, with 24 years of experience, testified at a PRRB evidentiary hearing related to PRRB Case Nos. 96-1882, 97-1579, 98-1827, and 99-2061. Ms. Cribbs worked with the preparation of the SSI file that was sent to CMS for the purpose of developing the SSI percentages for

hospitals. In her testimony, Ms. Cribbs stated that in order for an individual to be included in the file that SSA sent to CMS, the individual would have to have been active with one of three pay codes (CO-1, MO-1 or MO-2) and have been getting paid at least a penny for the month in question.

Thus the numerator of the SSI fraction requires payment, and Intermediaries are arguing that payment is not required for days to be included in the denominator. An obvious inequity therefore exists. If the denominator of the SSI fraction includes days that were not paid by Medicare, then the numerator of the SSI fraction should include days for patients that may not have received payment as well.

SSI Sub Issue 1D – SSI Percentage – Not In Agreement with Provider's Records

The Provider has learned that similar to Loma Linda Community Hospital v. Dept. of Health and Human Services, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.

The Provider has reason to belief, based upon this data in its possession, that the joint eligible beneficiary percentage determined by CMS is incorrect. The Provider will request SSI data from CMS. Once the Provider has received the requested information it will reconcile its records with the CMS data and identify records that CMS may have failed to include in their determination of the SSI percentage. The Provider will then seek verification from the Social Security Administration to verify SSI entitlement for those patients CMS may have failed to include in their determination of the SSI percentage.

SSI Sub Issue 1E – SSI Percentage – Findings of the PRRB and District Court in Baystate Case

Additionally, in a recent PRRB decision (2006-D20, Baystate Medical Center) the Board ruled that there are fundamental problems with the development of the SSI percentage. More specifically the PRRB ruled that the match process between CMS' MEPAR and SSI data file is flawed in that:

- It fails to match SSI eligible beneficiaries who do not receive Title II numbers
- It fails to use multiple identifiers

- It fails to match on a unique identifier
- It fails to match SSI eligible beneficiaries whose Tile II number changes within the year
- The flawed match may deflate the SSI percentage

The PRRB also ruled that the SSI data used for the Medicare percentage numerator is incomplete in that it omits the following SSI eligible beneficiary records:

- Prior to FFY 1995, inactive SSI records (stale records)
- Records relating to individuals who received a forced or manual payment
- Records of individuals whose benefits were temporarily on hold or in suspense when SSA ran the tape for CMS
- Records of SSI days associated with individuals whose benefits were granted or restored retroactively after SSA ran each year's tape
- Records of individuals who were entitled to non-cash Federal SSI benefits

Some of the other findings of the PRRB in the Baystate [*sic*] were as follows:

- The incomplete SSI data tends to deflate the DSH percentage
- Data used for the calculation of the DSH is not the best available data
- The denominator of the Medicare calculation is inaccurate as revealed by unexplained discrepancies
- The Provider is not required to quantify the financial impact of each of the flaws identified, nor is it required to show an exact number of incorrectly counted days
- The impact of the inaccuracies in the DSH calculation is likely to be significant, especially for some hospitals
- There is no significant administrative burden to redesigning the computer programs to capture accurate information and to accurately match SSI data with MEDPAR data

These findings have been upheld in large part by the United States District Court for the District of Columbia in Baystate Medical Center v. Michael O. Leavitt Civil Action No. 06-1263.[47]

[47] Appendix A at Bates Nos. 000120-122 (emphasis in original).

While Issue 1 is very, very detailed, it clearly does ***not*** discuss or reference Medicare Part C or Medicare + Choice or DSH Medicare Part C days or DSH managed care days or DSH HMO days. Moreover, Issue 1 does not even discuss dual eligible days generally. In this regard, the Board recognizes that, for appeals prior to 2010, it granted certain provider requests to bifurcate the DSH Part C days issue from the dual eligible days issue pending before the Supreme Court in *Becerra v. Empire Health Found.* (whereby providers are challenging the FY 2005 IPPS Final Rule and are seeking to have no-pay Part A days removed from the SSI fraction and added to the numerator of the Medicaid fraction to the extent those days involve a dual eligible ("the *Empire* dual eligible days issue") because there was some initial confusion in the provider community about whether the DSH Part C days issue was issue separate and distinct from the *Empire* dual eligible days issue since both policies were adopted concurrently in the ***same*** final rule, *i.e.*, the FY 2005 IPPS Final Rule.[48] However, it is clear that Valley did ***not*** even include the *Empire* dual eligible days issue in Issue 1 above (much less any other part of its appeal request for FY 2006).

Moreover, a review of the other 4 issues included in Valley's FY 2006 individual appeal confirms that the DSH Part C issue was ***not*** located elsewhere in Valley's appeal. The other issues in the Valley's appeal request were Issue 2 (DSH Medicaid Eligible Days), Issue 3 (DSH Medicaid Eligible Patient Day – General Assistance), Issue 4 (DSH Payment – Medicaid Eligible Washington Charity Care Days), and Issue 5 (DSH Payment – No Pay Part A Days). The only other issue that could have been potentially related to the DSH Part C days issue was Issue 5 but it only pertained to no-pay Part A days that had been *excluded* from ***both*** the Medicare ***and*** Medicaid fractions (and as such it was ***not*** the *Empire* dual eligible days issue and did ***not*** challenge the FY 2005 IPPS Final Rule).[49] Indeed, Issue 5 was *not* transferred to Case No. 09-2071GC, but rather was transferred to a different CIRP group under Case No. 08-2955GC for which the Board issued PRRB Dec. No. 2018-D43, which again does *not* encompass the Empire dual eligible days issue.[50]

---

[48] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021), *reviewing*, *Empire Health Found. v. Azar*, 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020) ("*Empire*"). The following developments made it clear that the DSH dual eligible days issue is a separate issue: *Northeast Hosp. Corp. v. Sebelius*, 699 F. Supp. 2d 81 (D.D.C. 2010); Board grant of EJR in PRRB Dec. No. 2010-D-38 (June 29, 2010); CMS Ruling 1498-R (Apr. 28, 2010).

[49] Issue 5 is based on the contention that "the Intermediary *did **not** allow* patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of ***either*** *the SSI percentage* ***or*** *the Medicaid Percentage* of the Medicare DSH calculation." *See* Appendix A at Bates No. 00124. Thus, the days at issue were ***not*** billed to Medicare Part A and were not part of the PS&R and, thus, were not included in the SSI fraction. As shown in the PRRB Dec. No. 2018-D43, this appeal did not challenge any aspect of the FY 2005 IPPS Final Rule (*e.g.*, it did not challenge either the DSH Part C days policy finalized in that rule or the DSH Dual Eligible days policy finalized in that rule).

[50] Appendix A to PRRB Dec. No. 2018-D43 documents Valley FY 2006 as a participant in Case No. 08-2955GC. Consistent with the Issue 5 issue statement for Valley FY 2006, the issue statement in PRRB Dec. No. 2018-D43 reads: "Should patient days associated with Medicare Part A, Title XIX eligible patients that were not included in the Supplemental Security Income ("SSI") percentage factor of the Medicare Disproportionate Share Hospital ("DSH") formula be included in the Medicaid days factor or the SSI percentage factor used in the Medicare DSH formula?" PRRB Dec. No. 2018-D43 is available at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/2018D43.pdf

When Valley filed its appeal for FY 2006 on or after October 1, 2008,[51] 42 C.F.R. § 405.1835(b) Aug. 21, 2008)[52] specified, in relevant part, that an appeal request contain the following information on "each specific item at issue":

> (b) *Contents of request for a Board hearing*. The provider's request for a Board hearing must be submitted in writing to the Board, and the request must include the elements described in paragraphs (b)(1) through (b)(4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraphs (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss with prejudice the appeal, or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the intermediary's or Secretary's determination under appeal.
>
> (2) **An explanation** (for each specific item at issue, see paragraph (a)(1) of this section) **of the provider's dissatisfaction** with the intermediary's or Secretary's determination under appeal, **including an account of all of the following**:
>
> (i) **Why the provider believes Medicare payment is incorrect for each disputed item** (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) **How and why** the provider believes Medicare **payment must be determined differently** for each disputed item.
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.[53]

Similarly, Board Rule 8 (Aug. 21, 2008) states:

---

[51] The certifications on the appeal request are signed and dated September 30, 2008 (Appendix A at Bates No. 000118) and document represents it was sent using the U.S. Postal Service Express Mail (Appendix A at Bates No. 000116). Accordingly, October 1, 2008 is the earliest Valley's appeal request for FY 2006 could have been filed.

[52] Valley filed its individual appeal request on or about October 1, 2008 (*see supra* note 51) which is after the revisions to the Board's governing regulations at 42 C.F.R. Part 405, Subpart R published at 73 Fed. Reg. 20190 (May 23, 2008) became effective on August 21, 2008.

[53] (Bold and underline emphases added.)

> **Rule 8 - Framing Issues for Adjustments Involving Multiple Components**
>
> **8.1 - General**
>
> Some issues may have multiple components. To comply with the regulatory requirement to *specifically identify* the items in dispute, each contested component must be appealed as a separate 7 issue and described as *narrowly as possible* using the applicable format outlined in Rule 7. See common examples below.
>
> **8.2 - Disproportionate Share Cases** (e.g., dual eligible, general assistance, charity care, HMO days, etc.)[54]

Here, Valley's appeal request for FY 2006 clearly failed to comply with § 405.1835(b) (Aug. 21, 2008) and identify the DSH Part C days by explaining "why . . . Medicare payment was incorrect" (*i.e.*, that Part C days were incorrectly included in the SSI fraction) and "how and why . . . Medicare payment should be determined differently" (*i.e.*, that Part C days should be removed from the SSI fraction and instead should be included in the numerator of the Medicaid fraction (as they pertain to patients also eligible for Medicaid). This failure becomes crystal clear when Valley's appeal request (as quoted above and a full copy of which is at Appendix A) is compared to Deaconesses' appeal request for FY 2007 (a copy of the issue statement is included at Exhibit 2 to the Providers' March 10, 2021 Response to RFI) as demonstrated by the following excerpts from Deaconess' appeal request that specifically relate to DSH Part C days and clearly comply with the § 405.1835(b) (Aug. 21, 2008) requirements:

> **Issue 3: Disproportionate Share Hospital Payment/Supplemental Security Income Percentage**
>
> **Description of the Issue**
>
> Whether the SSI Percentage used in the Medicare DSH calculation by the Intermediary accurately and correctly accounts for all patient days that must be included in the numerator and denominator of the SSI calculation.
>
> ****
>
> Removal of Part C Days from the Denominator of Medicare Fraction
>
> According to Medicare Statute and Regulations the SSI percentage is to be determined based upon the number of patients entitled to

[54] (Italics and underline emphases added.) Copy available at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.

both SSI and Medicare Part A. CMS included Medicare Part C/Medicare + Choice patients in the calculation of the Provider's SSI percentage. As clarified in the Federal Register of May 19, 2003, an individual is eligible to elect a Medicare + Choice plan if he or she is entitled to Medicare Part A and enrolled in Part B however once the beneficiary has elected to join a Medicare + Choice plan their benefits are no longer administered under Part A. CMS therefore clarified in the proposed rule that once a beneficiary elected Medicare Part C, those patent [*sic*] days attributable to the beneficiary should be included in the Medicaid fraction and not be included in the Medicare fraction of the DSH patient percentages. The Provider contends that the Intermediary's calculation of the DSH Payment adjustment is not in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) because Medicare Part C days have been included in the denominator of the Medicare Percentage. . . .

Issue 4 Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days For Cost Reporting Periods Ending On or After September 30, 2005

Description of the Issue

Whether the Intermediary properly excluded Medicare Managed Care Part C days to cost reporting periods ending on or after September 30, 2005, from the DSH calculation.

Statement of the Legal Basis

The Provider contends that the Intermediary did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, the Medicaid days proxy, set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.

The Provider contends that the Intermediary's treatment of the Managed Care Part C days for the Provider's Fiscal Year End December 31, 2007, is not in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The Intermediary failed to include patient days applicable to Medicare Managed Care Part C patients who were also eligible for Medicaid in the Medicaid fraction for Medicare DSH payment adjustment calculation purposes. . . .

Accordingly, the Board must find that, pursuant to 42 C.F.R. § 405.1835 (Aug. 21, 2008) and Board Rule 8 (Aug. 21, 2008), Valley never appealed the DSH Part C days issue for FY 2006.[55]

Moreover, the Board reaffirms that Case No. 09-2071GC never *properly* had the DSH Part C days issue included in that CIRP group appeal notwithstanding what the group issue statement (as shown at Appendix A at Bates Nos. 000133-135) may have stated. 42 C.F.R. § 405.1837(a) (Oct. 1, 2008) sets forth a provider's right to hearing as part of a group and states in pertinent part:

> (a) *Right to Board hearing as part of a group appeal; criteria*. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination for the period, **only if**—
>
> (1) **The provider satisfies individually the requirements for a Board hearing under §405.1835(a)**, except for the $10,000 amount in controversy requirement under §405.1835(a)(2) of this subpart;
>
> (2) The matter at issue in the group appeal involves **a single question** of fact or interpretation of law, regulations, or CMS Rulings **that is common to each provider in the group**; . . . .[56]

Thus, subsection (a)(2) makes clear that there can only be one issue per group and that issue must be common to each and every participant in the group. Similarly, subsection (a)(1) makes clear that, in order to participate in a group, the provider must first have properly appealed the group issue. Accordingly, since a group can only be comprised of common issues, the founding participant in a group must have the group's common issue.[57]

---

[55] The Board has no record of Valley adding issues to its FY 2006 individual appeal under Case No. 09-0109 and QRS has not alleged otherwise. In this regard, the Board notes that, as a result of the revisions to the Board's governing regulations issued in the final rule published on May 23, 2008, Valley had until October 20, 2008 to add any issues to its individual appeal. *See* 73 Fed. Reg. 20190, 30240 (May 23, 2008) (stating "For appeals pending before . . . the Board prior to the effective date of this rule, a provider that wishes to add one or more issues to its appeal must do so by the expiration of . . . 60 days after the effective date of this rule [*i.e.*, 60 days after August 21, 2008]."). *See also* Board Alert 3. This deadline to add issues was well before the actual transfer request that Valley made to Case No. 09-2071GC in July 2009 and, significantly, there was no pre-October 20, 2008 "add issues" document included with that transfer request packet, rather only a copy of Valley's original appeal request. Accordingly, the Board must conclude that there was no add issue request (or, if they were one, it was not relevant to the transfer to Case No. 09-2071GC since it was *not* included in the packet used to establish Case No. 09-2071GC and transfer Valley from Case No. 09-109).

[56] (Bold and underline emphasis added.)

[57] *See* 42 C.F.R. §§ 405.1837(a), 405.1837(b)(1)(i), 405.1837(b)(3) (stating "With respect to group appeals brought under paragraph (b)(1) of this section, one or more commonly owned or operated providers must make a written request for a Board hearing as a group appeal in accordance with paragraph (c) of this section. Any group appeal filed by a single provider must be joined by related providers on common issues in accordance with paragraphs (b)(1) and (e) of this section."), 405.1837(f)(1) (stating "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, a provider may not add other questions of fact or law to the

Here, QRS contends that the CIRP group under Case No. 09-2071GC included multiple issues, notwithstanding the fact that, pursuant to § 405.1837(a)(2), a group may only have "a ***single*** question of fact or interpretation of law, regulations, or CMS Rulings that is *common to* ***each*** provider in the group."[58] To this end, 42 C.F.R. § 405.1837(f)(1) makes it clear that, after the Board receives a group appeal request, "a provider may not add other questions of fact or law to the [group] appeal." Accordingly, it is clear that Valley as the founding member of a group only had the right to establish a group appeal for an issue for which it had a proper appeal in the first instance. Here, Valley's FY 2006 individual appeal did *not* include the DSH Part C days issue and, as such, it was an impossibility for it to serve as the founding member of any group *with the DSH Part C days issue*. Thus, notwithstanding QRS' position or the wording of the issue statement included for the group appeal, the group under Case No. 09-2071GC cannot contain the DSH Part C days issue, not only because Valley, as the founding member based on its FY 2006 appeal, did not appeal that issue but also because that issue clearly was not "common to each provider in the group" as required by § 405.1837(a)(2).

Indeed, when one actually reads through the group issue statement used to establish Case No. 09-2071GC, Medicare Part C is mentioned only in one place and it was for an issue *other than* the one in the instant case. Specifically, the group issue statement for Case No 09-2071GC references Part C days in the context of an alleged ***undercounting*** of SSI days included in the *numerator* of the SSI fraction (as opposed what the Providers are seeking in the instant case which is to have Part C days *excluded* from the SSI fraction and included in the numerator of the Medicaid fraction). The paragraph in question is at Bates No. 00135 of Appendix A and states:

> **Covered Days vs. Total Days**
>
> The Provider contends that the SSI percentage published by CMS for the given cost report were incorrectly computed. CMS divided the number of SSI days by the total number of Medicare patient days. In years past, CMS has divided the number of SSI days by the covered number of Medicare Part A days, not the total Medicare days. *See* 69 Fed. Reg. 48916 at 49098 (Aug. 11, 2004). CMS has said that "our Policy has been that only covered patient days are included in the Medicare fraction." According to 52 C.F.R. § 412.106(b)(2), Medicare Part B days do not belong in the denominator, and the SSI percentage must use covered days. By using total Medicare days in the denominator, the SSI percentage is deflated due to the inclusion of Medicare Part A, Part B and Part C days. If total Medicare days are to be used in the denominator, the SSI percentage is deflated due to the inclusion of Medicare Part A,

---

appeal, regardless of whether the question is common to other members of the appeal (as described in §405.1837(a)(2) and (g) of this subpart).") (Oct. 1, 2008).

[58] (Emphasis added.)

> Part B and Part C days. *If total Medicare days are to be used in the denominator then total SSI days must be used in the numerator*.[59]

Accordingly, not only did Valley as the founding participant not appeal and transfer the DSH Part C days issue into the group, but also the group issue statement clearly failed to include the DSH Part C days issue that was the subject of the EJR request filed in Case No. 17-0555GC.

Based on the above findings, it is a fiction that Case No. 09-2071GC was a "mixed" appeal *with the DSH Part C days issue* (as that term "mixed" is used in CMS Ruling 1498-R), resulting in the DSH Part C days issue somehow being part of the remand that the Board made for Case No. 09-2071GC pursuant to CMS Ruling 1498-R. Not only was the DSH Part C days issue *not* part of Case No. 09-2071GC, it was *not* part of the three issues covered by CMS Ruling 1498-R.[60] Indeed, a year after establishing Case No. 09-2071GC in July 2009, Empire Health established a separate DSH Part C days CIRP Group under Case No. 10-1172GC in July 2010. Had Valley FY 2006 included the Part C days as part of its original appeal under Case No. 09-0109, then the Board would have expected it to be a participant in Case No. 10-1172GC, similar to Deaconess FY 2007 which *did* include the Part C Days issue in its original appeal request (as shown in Exhibit 2 attached to QRS' March 10, 2021 Response to RFI) and *did* transfer to the DSH Part C Days issue Case No. 10-1172GC.[61] Like Deaconess FY 2007, Valley FY 2006 had an opportunity to appeal the DSH Part C days issue as part of its appeal request but failed to do so. Thus, when the Medicare Contractor issued Valley's revised NPR for FY 2006, it did not contain any residual rights related to DSH Part C because no such appeal rights were existing in Case No. 09-2071GC at the time the Board remanded that case pursuant to CMS Ruling 1498-R. Further, it is undisputed that the SSI percentage was *not* adjusted or changed upon remand. Pursuant to 42 C.F.R. § 405.1889(b), the scope of a provider's appeal of a revised determination is limited to "those matters that are specifically revised in a revised determination." Since there was no adjustment to the SSI fraction, the Board must find that it lacks jurisdiction over Valley FY 2006.

Based on the above findings, the Board dismisses Valley for FY 2006 from Case No. 17-0555GC.

2. Deaconess for FY 2007

As set forth below, the Board finds that the question of whether it has jurisdiction over Deaconess for FY 2007 as part of Case No. 17-0555 (or even Case No. 09-2071GC) is now moot as a result of the D.C. Circuit's 2014 decision in *Allina Health Services v. Azar* ("*Allina*") and the Board's decision to EJR Case No. 10-1172GC for the DSH Part C days issue. Further, the Providers' claim that the issue in Case No. 17-0555GC is somehow different from the issue in Case No. 10-1172GC cannot withstand any level of scrutiny.

---

[59] (Underline and italics emphases added.)

[60] CMS Ruling 1498-R was issued on April 28, 2010 and by its terms, only applied to the 3 issues as described in Sections 1, 2, and 3 of that Ruling and those 3 sections did not pertain to the DSH Part C Days issue. Rather, the Secretary did not issue a Ruling to address the DSH Part C Days issue until it issued CMS Ruling 1739-R on August 4, 2020.

[61] Deaconess FY 2007 is listed as a participant in the SoP for Case No. 10-1172GC included in Appendix A attached to the Board's decision to grant EJR for Case No. 10-1172GC on April 12, 2019. A copy of the Board's decision is included at Exhibit 6 to the Providers' March 10, 2021 Response to RFI.

The Board recognizes that, when appeals first began challenging the DSH Part C days issue policy, it originally took the position that, when those appeals requested that Part C days be excluded from the Medicare fraction and instead that such days be included in the numerator of the Medicaid fraction (to the extent the underlying patient was also Medicaid eligible), the appeal involved two separate issues. Accordingly, in those situations, when it identified DSH Part C days groups that requested both the exclusion of Part C days from the Medicare fraction and inclusion of such days in the numerator of the Medicaid fraction (to the extent the days involved a Medicaid eligible patient), the Board would bifurcate the appeal.

Further, it is true that the group issue statement filed in July 2010 to establish Case No. 10-1172GC focuses on the Medicaid fraction:

> Whether the Intermediary properly excluded Medicare Managed Care Part C days to cost reporting periods ending on or after September 30, 2005, from the DSH calculation. . . . The Intermediary failed to include patient days applicable to Medicare Managed Care Part C patients who were also eligible for Medicaid in the Medicaid fraction for Medicare DSH payment adjustment calculation purposes.[62]

In this regard, QRS argues that the issues in the two appeals are distinct because Case No. 10-1172GC involved whether Part C days should be included in the *Medicaid* fraction, and Case No. 17-0555GC involved whether they should be included in the *Medicare* fraction.[63] The Board disagrees with this argument put forth by the Provider because the issue statement in Case No. 17-0555GC is essentially the same:

> Whether HMO / Medicare Plus Choice / Medicare Managed Care / Medicare Part C / Medicare Advantage ("MA") Days were properly accounted for in the Disproportionate Share Hospital ("DSH") calculation. . . . The MAC failed to include patient days applicable to MA patients who were also eligible for Medicaid in the Medicaid Fraction of the Medicare DSH payment adjustment, but instead included those days in the SSI or Medicare fraction.[64]

To the extent there is any distinction between the groups, it has become moot because the D.C. Circuit's 2014 decision in *Allina Health Services v. Azar* makes it clear that "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[65] In other words, under 42 U.S.C. § 1395ww(d)(5)(F)(vi), either a Part C enrollee continues to be "entitled to benefits under Part A" or not. Accordingly, the two Part C Days issues cited by the Provider is really one issue

[62] PRRB Case 10-1172GC Initial Appeal Request, Issue 4 (July 23, 2010).
[63] Provider's Response to RFI at 6.
[64] PRRB Case 17-0555GC Group Appeal Request, Group Issue Statement (Nov. 30, 2016).
[65] 746 F.3d 1102, 1108 (D.C. Cir. 2014).

since the legal outcome is binary: either the Provider is successful in excluding Part C days from the SSI fraction (which in turn necessarily means they must be included and counted in the Medicaid fraction); ***or*** the Provider is unsuccessful in excluding them (which in turn necessarily precludes them from being counted in the Medicaid fraction). In making this finding, the Board views the D.C. Circuit's interpretation of the statute to be controlling precedent because the Provider could bring suit in the D.C. Circuit.[66]

To this end, the Group Representative filed, in essence a single *consolidated* EJR request for 8 CIRP groups[67] of which there were the following 3 Empire Health CIRP groups:

- Case No. 10-1172GC QRS Empire Services 2005-2008 Part C CIRP Group
- Case No. 17-0555GC QRS Empire Health 2005-2007 – Part C Days CIRP Group
- Case No. 15-3484GC QRS Empire Health 2008 SSI – Part C Days CIRP Group

The consolidated EJR request alleged the same issue for each of these groups, posed the same question for EJR and asked for the same relief. Accordingly, consistent with the D.C. Circuit's holding in *Allina*, the Board's EJR decision granting EJR for each of these groups was the same, meaning it granted EJR for the same legal question, namely that the Board "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." The Board recognizes that, under the operation of 42 C.F.R. § 405.1837, the Board should have either dismissed any duplicate appeals or required consolidation of these multi-year cases;[68] however, for purposes of administrative ease and the fact that no further proceedings would occur before the Board, the Board opted not to require consolidation of these multi-year CIRP groups given that they were under the same consolidated EJR umbrella and were being

---

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

[67] The use of the term "consolidated" is meant to capture the fact that the EJR request applies equally to all 8 CIRP group cases because that request is captioned for all 8 CIRP group cases and, consistent with that caption, filed in all 8 CIRP group cases.

[68] The Board views this multi-year CIRP situation presented here as an outlier and not reflective of Board practice (and outside of the unique Medicare/Medicaid fraction companion case situations discussed in *infra* note 69). In fact, upon closer review, the Board finds it erred in not consolidating these 3 multi-year appeals consistent with 42 C.F.R. §§ 405.1837(a), (b)(1) and (e)(1). If there are duplicate appeals, it is the Board's general practice to, as appropriate and as determined on a review of the underlying facts, to dismiss any duplicate appeals or require consolidation consistent with 42 C.F.R. 405.1837 which specifies that there can only be one CIRP group for a common issue in a particular year. In this regard, the Board notes that 42 C.F.R. 405.1837(e)(1) states: "When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal."

decided as one grouping.[69] Indeed, the Board notes that 2 of these CIRP groups each contains one or more participants that are ***not*** in the other 2 CIRP groups. The Board finds it difficult to believe that the Group Representative is somehow treating the Board's EJR grant for Valley FY 2005 in Case No. 17-0555GC different from the Board's EJR grant for Valley FY 2007, Deaconess FY 2005 and Deaconess FY 2006 in Case No. 10-1172GC, even though each of these participants only appear in one of those 3 CIRP groups.[70]

Accordingly, the Board finds that whether the Board has jurisdiction over Deaconess for FY 2007 in Case No. 17-0555GC is now moot because Deaconess FY 2007 as a participant in Case No. 10-1172GC was granted EJR for the compete Part C days issue (*i.e.*, the Part C days issue for which the Board granted EJR encompassed both the Medicare and Medicaid fractions). Thus, pursuant to Board Rule 4.6 which prohibits duplicate appeals and 42 C.F.R. § 405.1837(a), (b)(i) and (e)(1), the Board dismisses Deaconess for FY 2007 from Case No. 17-0555GC.

B. If the Administrator or the District Court were to find that the Board erred in its above dismissal of Valley FY 2006 and/or Deaconess 2007 because one, or both, of these dismissals was contrary to the Remand Orders, then the Board would remand the relevant Provider(s) pursuant to CMS Ruling 1739-R.

If the Administrator or the District Court were to find that the Board erred in its above dismissal of Valley FY 2006 and/or Deaconess 2007 because one, or both, of these dismissals was contrary to the Remand Orders, then the Board would remand the relevant Provider(s) pursuant to CMS Ruling 1739-R. The following excerpt from CMS Ruling 1739-R demonstrate the broad applicability of the Ruling to appeals involving DSH Part C days issues:

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals *regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions* of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are

[69] The Board notes that, at that time, the Board was processing hundreds of Part C EJR requests and, in the interests of timeliness, whenever a consolidated EJR request encompassed a Part C CIRP group for the Medicaid fraction and a Part C CIRP group for the Medicare fraction for the same year, the Board opted not to conduct these consolidations of the companion Medicare/Medicaid fraction cases since the EJR request and the EJR decision was being made in the context of a consolidated decision umbrella and since the filing of these companion Medicare/Medicaid fraction CIRP groups was presumably based on the Board's prior pre-*Allina* practice of requiring separate CIRP groups in that instance. However, if the Group Representative had requested, and the Board had granted, EJR over only say the Part C CIRP group for the Medicaid fraction and the Board later discovered that EJR had not been requested on the sister Part CIRP group for the Medicare fraction, then it has been the Board's practice in those situations to dismiss the Part C CIRP group for the Medicare fraction as being duplicative because the EJR requested, and granted, encompassed the ***complete*** Part C issue. *See supra* note 68.

[70] Compare the participants in the SoP for Case No. 10-1172GC to the SoP for Case No. 17-0555GC as attached to the Board's EJR decision dated April 12, 2019. A copy of this decision is available at Exhibit 6 to the Providers' March 10, 2021 Response to RFI.

> issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Ruling requires that the PRRB remand any otherwise jurisdictionally proper challenge *raising* ***this issue*** to the appropriate Medicare contractor.[71]

While the Providers here argue that their appeal is not within the scope of CMS Ruling 1739-R because they contend that they are not challenging the procedural validity of CMS' policy on DSH Part C days based on inadequate notice and comment,[72] the Board rejects this alleged distinction and finds that Valley Hospital should be remanded to the Medicare Contractor pursuant to CMS Ruling 1739-R. The Group Issue Statement in Case No. 17-0555GC specifically cites to *Allina* to support its arguments, noting that the *Allina* Court found that the final rule for Part C days was procedurally defective, ***and*** specifically requests that "the Board incorporate the entire administrative record[] of . . . *Allina* into the record of this appeal." Furthermore, the EJR request (which included both Case Nos. 17-0555GC and 10-1172GC) filed on March 20, 2019, makes *Allina* central to its EJR request as demonstrated by the following except from Section I.A entitled "The Providers; The Providers' Appeals" and Section I.C entitled "EJR Is Appropriate":

> A. The Providers; The Providers' Appeals
>
> . . . [T]he Providers identified in the Schedules of Providers . . . submit this request for [EJR] regarding the Providers' appeals . . . of 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). (The "Part C Days Issue").
>
> ****
>
> C. EJR Is Appropriate
>
> 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 (b)(2)(iii)(B). (The "2004 Rule") The Board is bound by the 2004

[71] CMS Ruling 1739-R at 1-2.
[72] Provider's Response to RFI at 11.

> Rule. The Provider respectfully submit, therefore that the Board should grant their request for EJR. . . .[73]

The EJR request further summarizes the *Allina* litigation as "the background for the Providers' challenge" to the validity of the 2004 final rule, along with how the Part C days policy at issue there was promulgated "without providing notice or the opportunity for comment[.]"[74] To the end in the final subsection of Section II entitled "Request for EJR," the Providers stated that they "seek a determination that the 2004 rule has no continuing validity after *Allina*, and that the Medicare Act and the APA preclude the Secretary from including Medicare Part C days in the Medicare Part A/SSI fractions . . . for the cost years at issue, *unless and until the Secretary* ***validly changes the regulation*** *applicable to those years*."[75] Thus, to the extent the Administrator or the reviewing District Court finds that the Board erred in dismissing Valley for FY 2006 and/or Deaconess for FY 2007Based on the above findings, the Board finds that CMS Ruling 1739-R would require the Board to remand the relevant Provider and the Board would do so.

Conclusion

Based on the above findings, the Board respectfully finds that it remains appropriate to dismiss both Deaconess (Prov. No. 50-0044) for FYE 12/31/2007 and Valley Hospital (Prov. No. 50-0119) for FYE 12/31/2006 from Case No. 17-0555GC and, accordingly, the Board hereby dismiss both Deaconess and Valley from Case No. 17-0555GC. Further, in the alternative, to the extent the Administrator or the reviewing District Court finds that the Board erred in dismissing Valley for FY 2006 and/or Deaconess for FY 2007, then the Board would remand the relevant Provider(s) pursuant to CMS Ruling 1727-R.

As there are no remaining providers in Case No. 17-0555GC, the Board closes it and removes it from the Board's docket. Review of the jurisdictional determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 1877 upon final disposition of the appeal.

Board Members Participating:

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

For the Board:

5/25/2022

X Clayton J. Nix

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

cc: Wilson Leong, Esq., FSS
Jacqueline Vaughn, Esq., CMS OAA

[73] Providers' Request for Expedited Judicial Review at 1-2 (Mar. 20, 2019).
[74] *Id.* at 4.
[75] *Id.* at 18-19.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Mail

Daniel Hettich, Esq.
King & Spalding, LLP
1700 Pennsylvania Ave., NW
Washington, D.C. 20006

RE: ***EJR Determination***
Provider: Froedtert Memorial Lutheran Hospital (Prov. No. 52-0177)
FYEs 06/30/2017, 06/30/2018
Case Nos. 22-0949 & 22-0982

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's April 28, 2022 request for expedited judicial review ("EJR"). The decision of the Board is set forth below.

Issue in Dispute

The issue for which EJR is requested is:

> [W]hether the formula for calculating the number of full-time equivalent ("FTE") residents a hospital may count in a year for the purpose of [DGME] reimbursement, as contained in 42 C.F.R. [§] 413.79(c)(2)(iii), is unlawful because it penalizes hospitals that train "fellows" (*i.e.,* residents who are not in their initial residency period) while operating in excess of their FTE caps.[1][2]

Background

The Medicare statute requires the Secretary[3] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME"). [4] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[5]

[1] Provider's EJR Request at 1-2.
[2] The Provider appealed this issue, as two distinct issues in their initial appeal requests. First issue was the DGME Fellow Penalty Present Year, and Second issue was the DGME Fellow Penalty Prior and Penultimate Years. The EJR covers both issues, collectively.
[3] of the Department of Health and Human Services.
[4] 42 U.S.C. § 1395ww(h).
[5] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).

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

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[6]

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

The Medicare Statute

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

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

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[7] ("*IRP residents*") are weighted at 100 percent or 1.0, while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "*fellows*") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[8] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

---

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

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[9]

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

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[10] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

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

[9] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[10] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[11]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[12] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

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

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

> (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
>
> plus
>
> (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[13]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[14] This regulation is the focus of these appeals and this EJR request, and it states the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[15]

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

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility that year.[16]

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

---

[13] *Id.* at 39894 (emphasis added).
[14] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that were in the prior version of the regulation and replacing them with reference to "the limit described in this section."
[15] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[16] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[17]

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

The Provider's Position

The Provider contends that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is unlawful because it further reduces a hospital's weighted FTE count in cases in which a hospital trains residents (whether IRPs or fellows) above the FTE cap. This reduction is accomplished by multiplying the weighted FTE count by a fraction consisting of the hospital's FTE cap (numerator) and the number of unweighted FTEs the hospital reported in that cost reporting year (denominator). This results in the hospital's allowable FTE count.[18]

The Provider points out that the regulation only applies when hospitals report residents in excess of their cap level. Consequently, if a hospital's unweighted FTE count for allopathic and osteopathic residents is less than or equal to its cap, its weighted FTEs are not reduced.[19]

The Provider asserts that the regulation for calculating allowable FTEs in 42 C.F.R. § 413.79(c)(2)(iii) has no basis in the text of the statute that it purports to interpret. Moreover, the Provider asserts that the regulation produces absurd results. The Provider explains that, if a hospital is training residents in excess of its cap, and some of its residents are fellows, under the regulation, each fellow that the hospital reports in excess of its cap will actually reduce its DGME reimbursement, otherwise known as "the fellow penalty." For these reasons, the Provider believes that the regulation is arbitrary and capricious, in excess of its statutory authority and should be held unlawful.[20]

Moreover, the Provider explains that the hospital's present-year FTE count is carried forward to become its prior-year FTE count in the following year, and the penultimate-year FTE count in the year after that. The Provider asserts that the regulation as applied in any year adversely affects reimbursement in subsequent years within the three-year rolling average. For this reason, the Provider is seeking a correction of the allowable FTE counts for its present, prior and penultimate cost reporting years.[21]

Since the FTE counts from the prior and penultimate years were determined in cost reporting periods preceding the payment years under appeal, the Provider notes that they may be considered by CMS to be "predicate facts." The Provider points out that CMS has interpreted the

[17] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[18] *Id.* at 1-2, 9-10.
[19] *Id.* at 8-10.
[20] *Id.* at 15-17.
[21] *Id.* at 1, 5, 10.

three-year limitations period in the reopening regulation at 42 C.F.R. § 405.1885(b)(2)(i) as prohibiting providers from appealing predicate facts in cost report appeals. However, that interpretation was rejected in *Saint Francis Medical Center v. Azar*[22] (*"St. Francis*") which concluded that "42 C.F.R. § 405.1885(b)(2)(i) does not apply to appeals from a fiscal intermediary to the PRRB."[23]

The Provider acknowledges that it did not self-disallow the DGME penalty issue on its Medicare cost reports for the reporting periods under appeal and stipulates to that fact. Moreover, the Provider asserts that even though it did not self-disallow the fellow penalty in its cost reports, the Provider is nonetheless entitled to payment because the self-disallowance regulation at 42 C.F.R. § 413.24(j) is unlawful. The Provider asserts that regulation is unlawful insofar as it requires providers to self-disallow items in their cost report if they seek payment that they believe "may not be allowable or may not comport with Medicare policy," even if such claims are futile because the Medicare Contractors have no authority to allow them.[24]

In sum, the Provider argues that the Board lacks the authority to decide the validity of CMS' regulation establishing the DGME fellowship penalty implemented through 42 C.F.R. § 413.79(c)(2). Further, the Board lacks the authority to determine the validity of 42 C.F.R. § 413.24(j) or grant the relief requested by the Provider pursuant to the substantive reimbursement requirement of an appropriate cost report claim under 42 C.F.R. § 413.24(j). For these reasons, the Provider asserts that the Board should grant its request for EJR on these two issues.[25]

The Medicare Contractor has not filed a response to the request for EJR and the time for doing so has elapsed.[26]

Decision of the Board

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

A. Jurisdiction

1. Jurisdiction over Appeals of Predicate Facts – the Prior and Penultimate Year Issues

   a. The 2013 Kaiser Case and CMS's Subsequent Revisions to 42 C.F.R. § 405.1885

[22] 894 F.3d 290 (D.C. Cir. 2018).
[23] *Id.* at 22-23 n.63.
[24] *Id.* at 2.
[25] *Id.* at 21.
[26] PRRB Rule 42.4 (2021).

In 2013, the D.C. Circuit issued its decision in *Kaiser Foundation Hospital v. Sebelius* ("*Kaiser*") holding that "the reopening regulation allow[ed] for modification of predicate facts in closed years provided the change will only impact the total reimbursement determination in open years."[27] The *Kaiser* case also involved the statutory cap on indirect medical education (IME) FTEs in base year cost reports, and the D.C. Circuit examined whether or not predicate facts could be corrected beyond the 3 year re-opening limit contained in 42 C.F.R. § 405.1885. In finding for the Providers, the D.C. Circuit rejected CMS' arguments that modification of predicate facts in closed years constitutes an impermissible reopening, and that even if not a reopening, the modification necessitates an adjustment to the closed year's reimbursement.[28]

CMS disagreed with the *Kaiser* decision, and in response, revised 42 C.F.R. § 405.1885 as part of the Calendar Year 2014 Outpatient Prospective Payment System and Medicare Ambulatory Surgical Center Payment System Final Rule ("CY 2014 OPPS/ASC Final Rule"). In the preamble to this final rule, CMS gave the following explanation for its revisions to § 405.1885:

> [W]e are adopting the proposed revisions to §§ 405.1885(a)(1) and (a)(2)(iv) to clarify that the specific "matters at issue in the determination" that are subject to the reopening rules include factual findings for one fiscal period that are predicate facts for later fiscal periods with the following modifications: We are adding language to paragraph (a)(1)(iii) that defines the "predicate facts" that are subject to the revisions as factual findings for one cost reporting period that once determined are used in one or more subsequent cost reporting periods to determine reimbursement. We are adding language to paragraph (b)(2)(iv) to clarify that it does not apply to factual findings when made as part of a determination of reasonable cost under section 1861(v)(1)(A) of the Act. Paragraph (a)(1)(iv) also was reworded for clarity. Absent a specific statute, regulation or other legal provision permitting reauditing, revising, or similar actions changing predicate facts:
>
> (1) A predicate fact is subject to change only through a timely appeal or reopening of the NPR for the fiscal period in which the predicate fact first arose of the fiscal period for which such fact was first determined by the intermediary; and/or
>
> (2) the application of the predicate fact is subject to change through a timely appeal or reopening of the NPR for the fiscal period in which the fact was first used (or applied), by the intermediary to determine the provider's reimbursement.[29]

CMS further stated that the revision to 42 C.F.R. § 405.1885 "would apply to *all* Medicare reimbursement determinations, and *not only* to direct GME payment, which was the particular

[27] *Kaiser Found. Hosps. v. Sebelius,* 708 F.3d 226, 229 (D.C. Cir. 2013).
[28] *Id.* at 229.
[29] 78 Fed. Reg. 74826, 75169 (Dec. 10, 2013).

issue in *Kaiser* . . . ."[30] CMS further stated that the revision would apply to any final determination "issued on or after the effective date of the final rule, and for any appeals or reopening . . . pending on or after the effective date of the final rule, even if the intermediary determination . . . preceded the effective date of the final rule."[31] The effective date of the revised 42 C.F.R. § 405.1885 was January 1, 2014.[32]

b. The Saint Francis Case

In June 2018, the D.C. Circuit revisited the issue of predicate fact as part of *Saint Francis*. Specifically, in *Saint Francis*, the D.C. Circuit reviewed CMS' 2013 revision to 42 C.F.R. § 405.1885 and held "that 42 C.F.R. § 405.1885 does not apply to appeals from a fiscal intermediary to the PRRB."[33] The Court reasoned that "[t]he reopening regulation applies *only* to reconsideration by the entity that made the decision at issue. It does not apply to administrative appeals."[34] The Court explained that a reopening occurs when various administrative actors within the agency reconsider *their own prior decisions*. The case was remanded to the agency for further proceedings consistent with the D.C. Circuit's opinion.

The Secretary has not formally acquiesced to the *Saint Francis* decision as of yet. The Board notes that the regulation was amended in 2020 but only in regard to language relating to mailing and receipt of requests to reopen.[35] However, it is clear from the *Saint Francis* case that the D.C. Circuit interpreted the reopening regulation at 42 C.F.R. § 405.1885 to *not* apply to appeals before the Board because they involve the Board reviewing a Medicare Contractor final determination. Further, the D.C. Circuit's decision in *Saint Francis* is controlling precedent for the interpretation of 42 C.F.R. § 405.1885 (as revised in 2013) because the Provider could bring suit in the D.C. Circuit.[36] Accordingly, the Board finds it is not bound by the Secretary's "longstanding policy" that predicate facts may only be redetermined by a timely appeal of the final determination in which the predicate fact first arose or was applied.

Based on the above, the Board finds that it has the authority to decide the FTE issue as it relates to the FTE counts for the prior and penultimate years under appeal because, under *Kaiser* and *Saint Francis*, providers may appeal and the Board may modify a predicate fact *as it relates to the open years under appeal.*

---

[30] *Id.* at 75165.
[31] *Id.*
[32] *Id.* at 74826.
[33] *Saint Francis Med. Ctr. v. Azar,* 894 F.3d 290, 297 (citation omitted).
[34] *Id.* at 294 (emphasis added).
[35] 85 Fed. Reg. 58432, 59019-20 (Sept. 18, 2020).
[36] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

2. Remaining Jurisdictional Findings

The Provider in these two individual cases appealed from two Medicare Contractor's NPR final determinations dated September 16, 2021 and January 13, 2022. The fiscal years under appeal are 6/30/2017 and 6/30/2018. The Provider filed timely appeals. The amounts in controversy each exceed the $10,000 threshold for individual appeals.[37] Accordingly, the Board finds that it has jurisdiction over these two cases pursuant to 42 C.F.R. § 405.1835.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. §§ 405.1873 and 413.24(j) for Cost Reports Beginning on or After January 1, 2016

1. Regulatory Background

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 405.1873 and 413.24(j) are applicable. The regulation 413.24(j) requires that:

> (1) *General Requirement.* In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—

[37] *See* 42 C.F.R. § 405.1835.

> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[38]

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.
>
> (b) *Summary of Procedures*.
> ***
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached

[38] (Bold and underline emphasis added.)

> under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .[39]

These regulations are applicable to the cost reporting periods in these two cases, which begin on July 1, 2017 (Case No. 22-0949) and July 1, 2018 (Case No. 22-0982).

2. Appropriate Cost Report Claims: Findings of Fact and Conclusions of Law

As explained above, at issue in these two appeals are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[40] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[41] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[42] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[43] The Medicare Contractor has failed to file a Substantive Claim Challenge within the time frame specified by Board Rule 44.5.1 (2021). However, as part of its request for EJR, the Provider stipulated that it did not self-disallow the specific items under appeal.[44] Specifically, the Provider states in its EJR Request that it "admittedly did not self-disallow the Fellow Penalty issue in its cost reports for the reporting periods under appeal and stipulates to that fact."[45]

As such, since a party to the appeal (the Provider) has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[46] the Board finds that there is a regulatory obligation for the Board to affirmatively review the appeal documents to determine whether an appropriate claim was made in the two appeals at issue. The Board notes that because the Provider has

---

[39] (Bold and underline emphasis added.)
[40] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[41] (Emphasis added.)
[42] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[43] *See* 42 C.F.R. § 405.1873(a).
[44] Provider's EJR Request at 2.
[45] Provider's EJR Request at 2.
[46] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

stipulated to the fact that it did not self-disallow and presented its legal arguments in its request for EJR, and the MAC had the opportunity to respond (as set forth in Board Rule 44.5.1) but did not, the Board finds that the parties have had an adequate opportunity to submit factual evidence and legal arguments on this issue.

The regulation at 42 C.F.R. § 413.24(j)(3) provides:

> ***Procedures for determining whether there is an appropriate cost report claim***. Whether the provider's cost report for its cost reporting period includes an appropriate claim for a specific item (as prescribed in paragraph (j)(1) of this section) must be determined by reference to the cost report that the provider submits originally to, and was accepted by, the contractor for such period, provided that none of the following exceptions applies:
>
> (i) If the provider submits an amended cost report for its cost reporting period and such amended cost report is accepted by the contractor, then whether there is an appropriate cost report claim for the specific item must be determined by reference to such amended cost report, provided that neither of the exceptions set forth in paragraphs (j)(3)(ii) and (iii) of this section applies;
>
> (ii) If the contractor adjusts the provider's cost report, as submitted originally by the provider and accepted by the contractor or as amended by the provider and accepted by the contractor, whichever is applicable, with respect to the specific item, then whether there is an appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the final contractor determination (as defined in § 405.1801(a) of this chapter) for the provider's cost reporting period, provided that the exception set forth in paragraph (j)(3)(iii) of this section does not apply;
>
> (iii) If the contractor reopens either the final contractor determination for the provider's cost reporting period (pursuant to § 405.1885 of this chapter) or a revised final contractor determination for such period (issued pursuant to § 405.1889 of this chapter) and the contractor adjusts the provider's cost report with respect to the specific item, then whether there is an appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the most recent revised final contractor determination for such period.

Applying that regulation here, the cost reports that the Provider originally submitted, and were accepted by, the contractor will be referenced to make this determination, as none of the exceptions in the regulation apply to the circumstances of these two cases.[47] Specifically, there is no evidence in the administrative records that the Provider submitted amended cost reports, or that the contractor reopened the final contractor determinations.[48] Further, while the contractor adjusted the Provider's cost reports with respect to DGME payments, the adjustments were not with respect to specific cost report claims for the DGME fellows penalty issue on appeal.[49]

On review of the Provider's Worksheet E-4 for the two periods at issue, the Provider did not self-disallow the specific item or issue under appeal.[50] With the appeal requests in these two cases, the Provider submitted its own worksheet to support its contention that its reimbursement for DGME is understated on Worksheet E-4 as a result of the issue under appeal. While the Provider submitted the separate worksheet on appeal, to comply with the regulation at 42 C.F.R. § 413.24 under the circumstances of these two cases, the Provider was required to submit that worksheet with its cost reports originally submitted to, and accepted by, the contractor, and there is no indication that the Provider did so. In sum, the Provider did not include estimated reimbursement amounts for each specific self-disallowed item(s) in the protested amount line(s) of the Provider's cost reports or attach a separate worksheet to the Provider's cost reports for each specific disallowed item, explaining why the Provider self-disallowed each specific item (instead of claiming full reimbursement in its cost reports for the specific items) and describing how the Provider calculated the estimated reimbursement amount for each specific disallowed item, as required by regulation.[51]

Based on the above and pursuant to 42 C.F.R. § 405.1873(d)(2), the Board finds in its specific findings of facts and conclusions of law that the Provider failed to make substantive claims pursuant to 42 C.F.R. § 413.24(j)(1)-(2) in these two cases and notes that this is undisputed as the Provider has stipulated to this fact.

C. EJR Request on the Validity of 42 C.F.R. §§ 413.24(j) & 405.1873

The Provider plainly admits that it did not protest the DGME fellows issue on its cost reports in compliance with what it describes as the "self-disallowance regulation" at 42 C.F.R. § 413.24(j) which is entitled "Substantive reimbursement requirement of an appropriate cost report claim" and specifies that "[i]n order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report . . . must include an appropriate claim for the specific item, by either – (i) Claiming full reimbursement in the provider's cost report for the specific item . . . ; or (ii) Self-disallowing the specific item in the provider's cost report . . . ." The Provider also that § 413.24(j) as well as and the related regulation at 42 C.F.R. § 405.1873

[47] *See* 42 C.F.R. § 413.24(j)(3).
[48] *See id.* at § 413.24(j)(3)(i), (iii).
[49] *See id.* at § 413.24(j)(3)(ii).
[50] *See Provider Reimbursement Manual*, Pt. II, ch. 40, § 1034 (June 30, 2015) ("Use this worksheet to calculate each program's payment (i.e., titles XVIII, and XIX) for direct graduate medical education (GME) costs as determined under 42 CFR 413.75 through 413.83. This worksheet applies to the direct graduate medical cost applicable to interns and residents in approved teaching programs in hospitals and hospital-based providers."
[51] *See* 42 C.F.R. § 413.24(j)(1)-(2).

are invalid. Accordingly, the Provider's Representative simultaneously requested EJR over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 in addition to the DGME fellows issue (discussed more fully, below).[52]

The Provider asserts that the "self-disallowance regulation" at 42 C.F.R. 413.24(j)(1)(ii) is unlawful insofar as it requires providers to expressly self-disallow claims for payment that they believe are not allowable under Medicare policy, even if such claims are futile because the MACs have no authority to allow them.[53] Moreover, the Provider contends that this requirement, which previously was for a jurisdiction requirement instead of a payment requirement, has been struck down by the Courts, citing the Supreme Court's decision in *Bethesda Hosp. Ass'n v. Bowen*[54] and a district court decision in *Banner Heart Hospital v. Burwell*.[55] The Provider asserts that, while the Board retains jurisdiction to hear the appeals of providers that have not complied with the "self-disallowance regulation," this regulation (along with its the companion regulation at 42 C.F.R. § 405.1873) strips the Board of its power to "affirm, modify or reverse a final determination of the" MAC as Congress granted in 42 U.S.C. § 1395oo(d).[56] Stated another way, the Provider contends that the "self-disallowance regulation" (along with its the companion regulation at 42 C.F.R. § 405.1873) essentially causes the following outcome: "the Board must hear providers' appeals, but it is powerless to pay them."[57]

The Provider readily acknowledges that it did not self-disallow the fellow penalty in its cost reports in these two cases, as required by 42 C.F.R. § 413.24(j) and asserts that it is nonetheless entitled to payment because that regulation is unlawful. In support of this contention, the Provider outlines several arguments, including that the self-disallowance regulation is contrary to the statute at 42 U.S.C. § 1395oo and is arbitrary and capricious because CMS has provided no explanation as to why the agency needs providers to present this information at the time they submit their cost reports.[58]

With regard to the Board's jurisdiction, the Provider points to 42 U.S.C. § 1395oo(f)(1), which allows a provider to obtain judicial review "of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (*on its own motion* or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question."[59]

Since there is no factual dispute regarding the Providers' lack of compliance with 42 C.F.R. § 413.24(j), the Board is bound by the regulation at 42 C.F.R. §§ 413.24(j) and 405.1873 (pursuant to 42 C.F.R. §405.1867) and does not have the authority to review their validity. Accordingly, EJR of the Providers' challenge to the validity of 42 C.F.R. §§ 413.24(j) and

[52] Provider's EJR Request at 1-2, 10-15, 17-21.
[53] *Id.* at 2, 13-14.
[54] 485 U.S. 399 (1988).
[55] 201 F.Supp.3d 131 (D.D.C. 2016); *see* Provider's EJR Request at 2, 11-13, 17-18.
[56] *Id.* at 13-14, 17.
[57] *Id.*
[58] *Id.* at 17-21.
[59] *Id.* at 21-22.

405.1873 is appropriate and the Board hereby, grants the Provider's EJR request on that challenge.

D. Board's Analysis of the DGME Fellows Penalty Issue

The Provider asserts that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between residents in their initial training period and fellows. The Provider asserts that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this formula results in the perceived disparate treatment between IRP residents and fellows.

$$\text{Allowable FTE count} = \text{Weighted FTE Count} \times \left(\frac{\text{Unweighted FTE Cap}}{\text{Unweighted FTE Count}}\right)$$ [60]

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[61] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[62] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the Provider that § 413.79(c)(2)(iii) essentially states the above equation, albeit in a slightly different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) states:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described

[60] EJR Request at 5-10, 15-17.
[61] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[62] 66 Fed. Reg. at 39894 (emphasis added).

> in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[63]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[64] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[65] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[66] (*i.e.*, ratios) using variables a, b, c, and d:

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

On the first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[67]

On the other side of the algebraic equation (*i.e.*, the ratio of "c / d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same proportion." This phrase expressed as a ratio ("c/d") is an *unknown* Weighted FTE Cap over the

---

[63] (Emphasis added.)
[64] *See* 62 Fed. Reg. at 46005 (emphasis added).
[65] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).
[66] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b; and
If a/b = c/d, then c = (a/b) x d.
[67] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

FY's Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

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

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

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

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

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

E. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over both the DGME Penalty Issue ***and*** the challenge to the validity of 42 C.F.R. §§ 413.24(j) for the subject years and that the Provider in this appeal is entitled to a hearing before the Board;

2) The Provider appealed cost reporting periods beginning after January 1, 2016 but failed to include "an appropriate claim for the specific item" that is the subject of the two individual appeals, as required under 42 C.F.R. § 413.24(j);

3) Based upon the Provider's assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), as well as the assertions regarding the validity of 42 C.F.R. §§ 413.24(j), 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 questions of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid ***and*** whether the regulation at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the DGME Penalty present, prior and penultimate year issues and the subject years. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject years. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. As there are no issues remaining in these two appeals, the Board hereby closes them and removes them from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

5/25/2022

X Clayton J. Nix

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

cc: Pamela VanArsdale, National Government Services, Inc.
Wilson C. Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Dylan Chinea & Thomas Knight
Toyon Associates, Inc.
1800 Sutter St., Ste. 600
Concord, CA 94520-2546

RE: *EJR Determination*
14-1289GC – *JMHS FY 2007 Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP*
16-0046GC – *John Muir Health 2011 Dual Eligible Part A Days in the SSI Ratio Issued 6/27/2013 Group Appeal*

Dear Mr. Chinea and Mr. Knight:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 29, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeals. The decision of the Board is set forth below.

I. Issue in Dispute

These two groups were created after the Providers sought to transfer the issue in dispute from individual appeals with one group for fiscal year 2007 and the other for fiscal year 2011.[1] In the requests for group appeals, the Providers stated the issue in dispute, identically, as follows:

> John Muir Health System (JMHS) disputes the SSI percentage developed by [the Centers for Medicare & Medicaid Services ("CMS")] and utilized by the [Medicare Administrative Contractor ("MAC")] in their updated calculation of Medicare Inpatient Prospective Payment System DSH payment. On May 3, 2010 CMS published CMS Ruling 1498-R pertaining to three Medicare DSH issues, one of which requires the inclusion of Medicare Part A non-covered days (such as exhausted benefit days and Medicare secondary payer days) in the SSI ratio of the Medicare DSH payment calculation.
>
> JMHS contends CMS' new interpretation of including Medicare Dual Eligible Part A Days in the SSI ratio issued on March 16, 2012 is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the *Northeast Hospital* decision. The

[1] Providers' Requests to Establish CIRP Group Appeal (Dec. 9, 2013 and Oct. 5, 2015).

> Secretary did not validly change her interpretation of the DSH calculation prior to FFY 2013, and because there is no statute that authorizes the Secretary to promulgate retroactive rules for DSH calculations, the Secretary cannot impose her new interpretation on the DSH payment calculation challenged in this case. JMHS's position is supported by the federal district court decision in *Allina Health Services, et al, v. Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services* (Civil Action No. 10-1463 (RMC)). JMHS maintains the position all unpaid Medicare Dual Eligible Part A Days should be included in the Medicaid patient day ratio of the Medicare DSH payment calculation.[2]

In the Providers' request for EJR, they frame the legal question as follows. The Providers, who are within the Ninth Circuit's jurisdiction, request a determination from the Board whether, in light of the Ninth Circuit's decision in *Empire Health Foundation for Valley Hospital Center v. Azar,* 958 F.3d 873 (9th Cir. 2020) ("*Empire*"), it has the authority to instruct the MAC to recalculate the Providers' DSH payments by no longer treating days that are not entitled to Part A payment as being "entitled to benefits under Part A" for purposes of both the Medicare and Medicaid DSH fractions.[3] If the Board determines it lacks that authority, the Board should grant EJR.[4] If the Board believes it has that authority by virtue of the Ninth Circuit's decision, it should remand to the MAC with instructions to recalculate the Providers' DSH payments by no longer treating days that are not entitled to Part A payment as nonetheless being "entitled to benefits under Part A" consistent with the ruling in *Empire.*[5]

Thus, it is clear from the Providers' issue statements that the Medicare Dual Eligible Part A Days in the SSI ratio issue impacts ***both*** the Medicare/SSI fraction and the Medicaid fraction of the DSH payment calculation. When framing issues for adjustments involving multiple components, Board Rule 8.1 requires that "each contested component must be appealed as a separate issue and described as narrowly as possible." Further, the statute and regulations governing group appeals specifically note that a provider has a right to a Board hearing as part of a group appeal with other providers "***only if*** . . . [t]he matter at issue in the group appeal involves a ***single*** question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group[.]"[6] Similarly, "[w]hen the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."[7] As discussed below in Section IV.C, the Board concludes that the Providers' challenge to the application of Dual Eligible , Non-Covered or Exhausted Part A Days in both the SSI and Medicaid fractions is two separate issues, even

---

[2] *Id.* (emphasis in original).
[3] Request for Expedited Judicial Review, 1 (Apr. 29, 2022) ("EJR Request").
[4] *Id.*
[5] *Id.* at 1-2.
[6] 42 C.F.R. § 405.1837(a)(2). *See also* 42 U.S.C. 1395oo(b) (noting that a group appeal is proper "***only if*** the matters in controversy involve a common question of fact or interpretation of law or regulations . . .").
[7] 42 C.F.R. § 405.1837(f)(2)(ii).

though they are identified in the Providers' appeal and EJR requests, and OH CDMS, as one combined issue. In this regard, the Board notes that it has historically required the formation of two separate groups for the Exhausted Part A Days issue as it relates to the SSI and Medicaid Fractions when the issue statement for the group request exclusion of no-pay Part A days from the SSI fraction and inclusion of the subset of those days involving dual eligible in the numerator of the Medicaid fraction.[8]

Since the Board has determined jurisdiction is proper for all participants of the two group appeals for both issues (as discussed in Section IV.A-B below), and for the sake of judicial economy, the Board is hereby bifurcating the two CIRP Group Appeals into the following cases, as reflected in the attached Schedules of Providers:

- 14-1289GC(A) – JMHS FY 2007 Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP/SSI Fraction
- 14-1289GC(B) – JMHS FY 2007 Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP/Medicaid fraction
- 16-0046GC(A) – John Muir Health 2011 Dual Eligible Part A Days in the SSI Ratio Issued 6/27/2013 Group Appeal/SSI Fraction
- 16-0046GC(B) – John Muir Health 2011 Dual Eligible Part A Days in the SSI Ratio Issued 6/27/2013 Group Appeal/Medicaid Fraction[9]

Accordingly, the Board is treating this EJR request as a consolidated EJR request to cover both issues, as discussed below.

II. Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

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

[8] The Board also takes administrative notice that, when processing EJR requests on these two issues, it is correcting any limited situations where the Board may have previously consolidated these two issues in error.
[9] As these cases have the same record up to this point and there will be no further proceedings before the Board following this decision, the Board has opted for purposes of administrative efficiency not to create separate case numbers within OH-CDMS at this time. Should additional proceedings before the Board occur in these cases on remand to the Board, then the Board would do so at that time, as appropriate and relevant.
[10] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[11] *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[14] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[15] The DPP is defined as the sum of two fractions expressed as percentages.[16] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[17]

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[19]

---

[12] *See* 42 U.S.C. § 1395ww(d)(5).
[13] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[14] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[15] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[16] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[17] (Emphasis added.)
[18] 42 C.F.R. § 412.106(b)(2)-(3).
[19] (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.[20]

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

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

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[23] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[24] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[25]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[26] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[27] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were

[20] 42 C.F.R. § 412.106(b)(4).
[21] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.* at 27207-27208.
[26] *Id.* at 27207-08.
[27] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.

hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[28]

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

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[32] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[33]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[34] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently *misstated* our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not

[28] 68 Fed. Reg. at 27208.
[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[33] *Id.*
[34] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[35]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[36]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[37] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[38] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[39]

[35] 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004) (emphasis added).
[36] *Id.* at 49099 (emphasis added).
[37] *Id.*
[38] *See id.* at 49099, 49246.
[39] (Emphasis added.)

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

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

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[41]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[42] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH

[40] (Emphasis added.)
[41] *Id.*
[42] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days are only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).

> regulation was effective for cost reports with patient discharges on or after October 1, 2004.[43]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[44] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[45] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[46] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[47] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[48] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[49] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[50] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[51]

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

---

[43] (Citations omitted and emphasis added.)
[44] 317 F. Supp. 3d 168 (D.D.C. 2018).
[45] *Id.* at 172.
[46] *Id.* at 190.
[47] *Id.* at 194.
[48] *See* 2019 WL 668282.
[49] 718 F.3d 914 (2013).
[50] 657 F.3d 1 (D.C. Cir. 2011).
[51] 718 F.3d at 920.
[52] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[53] *Id.* at 1141.
[54] *Id.*

have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[55] and that the regulation is procedurally invalid.[56]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[57] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[58] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[59] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[60] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[61] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[62] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[63] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[64] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

---

[55] *Id.* at 1162.
[56] *Id.* at 1163
[57] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[58] *Id.* at 884.
[59] *Id.* at 884.
[60] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[61] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[62] *Id.* at 886.
[63] *Id.*
[64] *Becerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

III. Providers' Position

The Providers are challenging the inclusion of certain non-covered (Part A exhausted or Medicare secondary payor) patient days in the Medicare (or SSI) fraction.[65] The Providers believe that the Ninth Circuit's decision in *Empire* entirely vacates the Secretary's 2005 Rule, discussed above, on a nationwide basis and that, at a minimum, the *Empire* ruling is binding for hospitals in the Ninth Circuit as the Providers argue CMS has seemed to recognize.[66] The hospitals in these group appeals are within the Ninth Circuit's jurisdiction, and thus the Providers argue that that decision is binding and remains in effect until the Supreme Court determines otherwise because the government did not request a stay of the decision pending Supreme Court review.[67] The Providers argue that if the Board believes it is bound by the Ninth Circuit's decision, the Providers request that the Board remand these cases to the MAC to recalculate all of the Providers' DSH payments consistent with the *Empire* ruling in which CMS' 2005 regulation was vacated and CMS' pre-2005 regulation under which only "covered" Part A days are treated as being "entitled to benefits under Part A" was reinstated.[68]

If instead, the Board believes it continues to be bound by CMS' 2005 regulation, and/or CMS Ruling 1498R, the Providers request that the Board grant EJR on this issue.[69]

IV. Decision of the Board

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

A. Jurisdiction for Appeals of Cost Report Periods Ending Prior to Dec. 31, 2008

The Providers in Case Nos. 14-1289GC(A) and 14-1289GC(B) have appealed cost reports with fiscal year ends ("FYEs") prior to December 31, 2008, namely, cost reports with FYEs of December 31, 2007.

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 an issue as a "self-disallowed cost,"

---

[65] EJR Request, at 1-3.
[66] *Id.* at 2-3, *citing* Pub. 100-09 Medicare Contractor Beneficiary and Provider Communications, Transmittal No. 11127 (Nov. 16, 2021) (calculating the 2019 SSI fractions for hospitals within the Ninth Circuit consistent with *Empire*); Transmittal No. 11276 (Feb. 24, 2022) (calculating the same for 2020).
[67] *Id.* at 1-3.
[68] *Id.*
[69] *Id.*

pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen*.[70] 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.[71]

The Board has determined that the unpaid Medicare Dual Eligible Part A Days issues are governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. As such, since the Providers filed their cost reports in compliance with this regulation, they are not barred from claiming dissatisfaction with the amount of reimbursement allowed by the regulation and, in turn challenging that regulation as part of these appeals.

In addition, the Providers' documentation for both Case Nos. 14-1289GC(A) and 14-1289GC(B) shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[72] The appeals were timely filed and no jurisdictional impediments for these issues have been identified. Finally, the Board notes that each Provider specifically included a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions in their respective individual appeals. Based on the foregoing, the Board finds that it has jurisdiction to conduct a hearing on the specific matter at issue in Case Nos. 14-1289GC(A) and 14-1289GC(B).

B. Jurisdiction for Appeals of Cost Report Periods Ending After Dec. 31, 2008 and Prior to January, 1, 2016

The Providers in Case Nos. 16-0046GC(A) and 16-0046GC(B) have appealed cost reports with FYEs of December 31, 2011.

1. Statutory and Regulatory Background

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[73] In that case, the Supreme Court concluded that a cost report submitted in full

[70] 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.).
[71] *Bethesda at 1258-59.*
[72] *See* 42 C.F.R. § 405.1837(a)(3).
[73] 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.).

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.[74]

On August 21, 2008, new regulations governing the Board were effective.[75] 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*").[76] 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.[77]

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

2. *Jurisdiction over Case Nos. 16-0046GC(A) and 16-0046GC(A) and the Underlying Participants*

The Board has determined that the Exhausted Part A/Dual Eligible Days issues in the above-captioned CIRP group cases are governed by CMS Ruling CMS-1727-R since they are challenging the FY 2005 IPPS Final Rule and that Board review of the issues is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[78] The appeals were timely filed and no jurisdictional impediments have been identified for the remaining participants. Finally, the Board notes that each Provider specifically included a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions in their respective individual appeals. Based on the foregoing, the Board

[74] *Bethesda*, 108 S. Ct. at 1258-59.
[75] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[76] 201 F. Supp. 3d 131 (D.D.C. 2016).
[77] *Id.* at 142.
[78] *See* 42 C.F.R. § 405.1837.

finds that it has jurisdiction to conduct a hearing on the specific matter at issue in Case Nos. 16-0046GC(A) and 16-0046GC(B).

C. Board's Analysis of the Appealed Issue

First, the Providers assert that the *Empire* ruling is binding for hospitals in the Ninth Circuit as the Providers argue that CMS has seemingly recognized that fact in CMS Transmittal No. 11127, which addresses the SSI/Medicare Beneficiary Data to be used in the calculation of DSH adjustments.[79] That transmittal directs Medicare Contractors to include only "covered days" in the SSI ratio, and provides as follows: "For IPPS hospitals in the Ninth Circuit's jurisdiction (Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon and Washington), these ratios include only "covered days" to reflect the decision of the 9th Circuit in Empire Health Foundation v. Azar (currently pending before the Supreme Court), to preliminarily settle cost reports."[80] However, that transmittal and the transmittal issued the following year to which the Providers cite, apply only for FY 2019 and FY 2020, respectively.[81] Importantly, the purpose of calculating those cost reports pursuant to *Empire* is to "preliminarily settle cost reports," and the transmittal notes that the Ninth Circuit's decision is currently pending before the Supreme Court. The cost reports at issue in this appeal have FYEs of December 31, 2007 and December 31, 2011, and thus those transmittals are not applicable to this appeal.

Further, 42 C.F.R. § 405.1867 specifies that "[i]n exercising its authority to conduct proceedings under this subpart, the Board **must** *comply with* all the provisions of Title XVIII of the Act and *regulations issued thereunder* . . . ."[82] Here the Secretary has not yet acquiesced to the Ninth Circuit's decision in *Empire* and has not otherwise retracted or revised the regulation at issue. Consequently, the Board finds that it continues to be bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Provider, namely: (1) invalidating the amendments FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issues and calendar year under appeal in this case.

In making this finding, the Board notes that, as described above, the Providers maintained in their EJR Request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated, and such days should instead be counted in the patient days ratio of the Medicaid fraction (to the extent the days involve a dual eligible), and that this is consistent with the *Empire* ruling. However, as evidenced by the Ninth Circuit's decision in *Empire,* the invalidation of the DSH no-pay Part A days policy (as finalized in the FY 2005 IPPS Final Rule) does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that the

[79] Transmittal No. 11127 (Nov. 16, 2021), and related MLN Matters Article No. MM12516, are available online at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r11127com.
[80] *Id.*
[81] *See id.*
[82] (Emphasis added.)

Ninth Circuit's decision in *Empire* only reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i) under which no-pay Part A days were counted in neither the Medicare fraction nor the Medicaid fraction.

Moreover, it is clear that the situation in the instant case is not as simple as the one presented in *Allina Health Services v. Sebelius* ("*Allina*").[83] In *Allina*, the Ninth Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in *Allina* stated: "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[84]

In contrast, this case involves no-pay Part A days and the subset of no-pay Part A days associated with dual eligibles. It is clear that the *class of patients* who are dually eligible do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, with respect to this *patient class*, any days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction and included in the Medicaid fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits).[85] To this end, the Providers are asserting that only in *certain* ***no-pay*** Part A situations that involve a dual eligible beneficiary (*e.g.*, exhausted benefits and MSP) must the days associated with this class of patients be excluded from the SSI fraction and included in the Medicaid fraction.

Similarly, the class of patients who have Medicare Part A includes dual eligibles and that, with respect to this larger patient class, any days associated with them may not be excluded *in toto* (*i.e.*, it is undisputed that some Part A patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits). Significantly, under the Providers' desired interpretation of the DSH statute, any days associated with no-Pay Part A days for which the beneficiary was *not* Medicaid eligible (*i.e.*, the patient was not a dual eligible) would not be counted in either the Medicare or Medicaid fraction.

Accordingly, the Board disagrees with the Providers' position that exclusion of days associated with no-pay Part A situations where the underlying patient is a dual eligible *automatically* means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to: (1) the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*");[86] and (2) CMS Ruling 1498-R, wherein multiple possible treatments of no-pay dual eligible days are discussed and wherein CMS reconfirms that its policy prior to October 1, 2004 was to exclude all no-pay Part A days from the Medicare and Medicaid fractions even where the underlying patient was also eligible for Medicaid, stating:

---

[83] 746 F.3d 1102, 1108 (D.D. Cir. 2014).
[84] *Id.* (emphasis added).
[85] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina*, the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[86] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients.

> Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI Fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 C.F.R. 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changed to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098).[87]

Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Medical Center v. Blue Cross Blue Shield Association* ("*Edgewater*").[88] Thus, in the event the Supreme Court upholds the Ninth Circuit's decision in *Empire,* the Providers would be arguing that CMS' prior policy of excluding from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.

Accordingly, the Board continues to maintain that the Provider's legal argument for the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the Provider's legal argument for the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the subset of no-pay part A days that involve patients who are eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating the Providers' EJR Request as a consolidated request involving two separate issues – Dual Eligible, Non-Covered or Exhausted Part A Days in both the SSI and Medicaid fractions.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter at issue for the subject years and that the Providers in Case Nos. 14-1289GC(A), 14-1289GC(B), 16-0046GC(A) and 16-0046GC(B) are entitled to a hearing before the Board;

---

[87] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.

[88] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater*").

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

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

4) It is without authority to decide the legal question in Case Nos. 14-1289GC(A) and 16-0046GC(A) of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid and the legal question in Case Nos. 14-1289GC(B) and 16-0046GC(B) of what policy should then apply, namely whether to exclude or include such no-pay Part A days which involve a dual eligible from the Medicaid fraction if all no-pay Part A days are excluded from the Medicare fraction.

Accordingly, the Board finds that the questions in Finding 4 properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and grants the Providers' consolidated request for EJR for the issues and the subject years.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. As there are no issues remaining in these appeals, the Board hereby closes them and removes them from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

5/26/2022

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson C. Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Thomas Knight & Kathleen Giberti
Toyon Associates, Inc.
1800 Sutter St., Ste. 600
Concord, CA 94520-2546

RE: ***EJR Determination***
14-3136GC – *SJHS FY 2008 DSH Medicare Dual Elig Part A Days in SSI Ratio Issued 3/16/12 CIRP Group*
14-3482GC – *SJHS FY 2009 DSH Medicare Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group*

Dear Mr. Knight and Ms. Giberti:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 29, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeals.[1] The decision of the Board is set forth below.

I. Issue in Dispute

These two groups were created after the Providers sought to transfer the issue in dispute from individual appeals with one group for fiscal year ending in 2008 and the other for fiscal year ending in 2009.[2] In the requests for group appeals, the Providers stated the issue in dispute, identically, as follows:

> St. Joseph Health System (SJHS) disputes the SSI percentage developed by [the Centers for Medicare & Medicaid Services ("CMS")] and utilized by the [Medicare Administrative Contractor ("MAC")] in their updated calculation of Medicare Inpatient Prospective Payment System DSH payment. On May 3, 2010 CMS published CMS Ruling 1498-R pertaining to three Medicare DSH issues, one of which requires the inclusion of Medicare Part A non-covered days (such as exhausted benefit days and Medicare secondary payer days) in the SSI ratio of the Medicare DSH payment calculation.
>
> SJHS contends CMS' new interpretation of including Medicare Dual Eligible Part A Days in the SSI ratio issued on March 16,

[1] The Providers' Request for EJR also included Case No. 17-1986GC. However, the Board will address that case in a separate document under separate cover.
[2] Providers' Requests to Establish CIRP Group Appeal (Apr. 3, 2014 and May 16, 2014).

> 2012 is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the *Northeast Hospital* decision. The Secretary did not validly change her interpretation of the DSH calculation prior to FFY 2013, and because there is no statute that authorizes the Secretary to promulgate retroactive rules for DSH calculations, the Secretary cannot impose her new interpretation on the DSH payment calculation challenged in this case. SJHS' position is supported by the federal district court decision in *Allina Health Services, et al, v. Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services* (Civil Action No. 10-1463 (RMC)). JMHS maintains the position all unpaid Medicare Dual Eligible Part A Days should be included in the Medicaid patient day ratio of the Medicare DSH payment calculation.[3]

In the Providers' request for EJR, they frame the legal question as follows. The Providers, who are within the Ninth Circuit's jurisdiction, request a determination from the Board whether, in light of the Ninth Circuit's decision in *Empire Health Foundation for Valley Hospital Center v. Azar,* 958 F.3d 873 (9th Cir. 2020) ("*Empire*"), it has the authority to instruct the MAC to recalculate the Providers' DSH payments by no longer treating days that are not entitled to Part A payment as being "entitled to benefits under Part A" for purposes of both the Medicare and Medicaid DSH fractions.[4] If the Board determines it lacks that authority, the Board should grant EJR.[5] If the Board believes it has that authority by virtue of the Ninth Circuit's decision, it should remand to the MAC with instructions to recalculate the Providers' DSH payments by no longer treating days that are not entitled to Part A payment as nonetheless being "entitled to benefits under Part A" consistent with the ruling in *Empire*.[6]

Thus, it is clear from the Providers' issue statements that the Medicare Dual Eligible Part A Days in the SSI ratio issue impacts ***both*** the Medicare/SSI fraction and the Medicaid fraction of the DSH payment calculation. When framing issues for adjustments involving multiple components, Board Rule 8.1 requires that "each contested component must be appealed as a separate issue and described as narrowly as possible." Further, the statute and regulations governing group appeals specifically note that a provider has a right to a Board hearing as part of a group appeal with other providers "***only if*** . . . [t]he matter at issue in the group appeal involves a ***single*** question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group[.]"[7] Similarly, "[w]hen the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."[8] As discussed below in Section IV.C, the Board

---

[3] *Id.* (emphasis in original).
[4] Request for Expedited Judicial Review, 1 (Apr. 29, 2022) ("EJR Request").
[5] *Id.*
[6] *Id.* at 1-2.
[7] 42 C.F.R. § 405.1837(a)(2). *See also* 42 U.S.C. 1395oo(b) (noting that a group appeal is proper "***only if*** the matters in controversy involve a common question of fact or interpretation of law or regulations . . .").
[8] 42 C.F.R. § 405.1837(f)(2)(ii).

concludes that the Providers' challenge to the application of Dual Eligible , Non-Covered or Exhausted Part A Days in both the SSI and Medicaid fractions is two separate issues, even though they are identified in the Providers' appeal and EJR requests, and OH CDMS, as one combined issue. In this regard, the Board notes that it has historically required the formation of two separate groups for the Exhausted Part A Days issue as it relates to the SSI and Medicaid Fractions when the issue statement for the group request exclusion of no-pay Part A days from the SSI fraction and inclusion of the subset of those days involving dual eligible in the numerator of the Medicaid fraction.[9]

Since the Board has determined jurisdiction is proper for all participants of the two group appeals for both issues (as discussed in Section IV.A-B below), and for the sake of judicial economy, the Board is hereby bifurcating the two CIRP Group Appeals into the following cases, as reflected in the attached Schedules of Providers:

- 14-3136GC(A) – SJHS FY 2008 DSH Medicare Dual Elig Part A Days in SSI Ratio Issued 3/16/12 CIRP Group/SSI Fraction
- 14-3136GC(B) – SJHS FY 2008 DSH Medicare Dual Elig Part A Days in SSI Ratio Issued 3/16/12 CIRP Group/Medicaid fraction
- 14-3482GC(A) – SJHS FY 2009 DSH Medicare Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group/SSI Fraction
- 14-3482GC(B) – SJHS FY 2009 DSH Medicare Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group/Medicaid Fraction[10]

Accordingly, the Board is treating this EJR request as a consolidated EJR request to cover both issues, as discussed below.

II. Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[11] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[12]

---

[9] The Board also takes administrative notice that, when processing EJR requests on these two issues, it is correcting any limited situations where the Board may have previously consolidated these two issues in error.
[10] As these cases have the same record up to this point and there will be no further proceedings before the Board following this decision, the Board has opted for purposes of administrative efficiency not to create separate case numbers within OH-CDMS at this time. Should additional proceedings before the Board occur in these cases on remand to the Board, then the Board would do so at that time, as appropriate and relevant.
[11] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[12] *Id.*

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[13] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[14]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[15] 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.[16] The DPP is defined as the sum of two fractions expressed as percentages.[17] 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 . . . .[18]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[19]

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*

[13] *See* 42 U.S.C. § 1395ww(d)(5).
[14] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[15] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[16] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[17] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[18] (Emphasis added.)
[19] 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.[20]

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.[21]

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

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[22] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[23]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[24] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[25] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[26]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[27] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[28] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied

---

[20] (Emphasis added.)
[21] 42 C.F.R. § 412.106(b)(4).
[22] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.* at 27207-27208.
[27] *Id.* at 27207-08.
[28] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.

from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[29]

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

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

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[35] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

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

[29] 68 Fed. Reg. at 27208.
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[34] *Id.*
[35] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[36]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[37]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[38] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[39] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and

[36] 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004) (emphasis added).
[37] *Id.* at 49099 (emphasis added).
[38] *Id.*
[39] *See id.* at 49099, 49246.

> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[40]

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

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

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

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[43] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a

[40] (Emphasis added.)
[41] (Emphasis added.)
[42] *Id.*
[43] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days are only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).

> practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[44]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[45] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[46] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[47] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[48] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[49] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[50] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp. v. Sebelius*,[51] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[52]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[53] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[54] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[55] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before

---

[44] (Citations omitted and emphasis added.)
[45] 317 F. Supp. 3d 168 (D.D.C. 2018).
[46] *Id.* at 172.
[47] *Id.* at 190.
[48] *Id.* at 194.
[49] *See* 2019 WL 668282.
[50] 718 F.3d 914 (2013).
[51] 657 F.3d 1 (D.C. Cir. 2011).
[52] 718 F.3d at 920.
[53] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[54] *Id.* at 1141.
[55] *Id.*

the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[56] and that the regulation is procedurally invalid.[57]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[58] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[59] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[60] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[61] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[62] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[63] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[64] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

---

[56] *Id.* at 1162.
[57] *Id.* at 1163
[58] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[59] *Id.* at 884.
[60] *Id.* at 884.
[61] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[62] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[63] *Id.* at 886.
[64] *Id.*

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[65] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

III. Providers' Position

The Providers are challenging the inclusion of certain non-covered (Part A exhausted or Medicare secondary payor) patient days in the Medicare (or SSI) fraction.[66] The Providers believe that the Ninth Circuit's decision in *Empire* entirely vacates the Secretary's 2005 Rule, discussed above, on a nationwide basis and that, at a minimum, the *Empire* ruling is binding for hospitals in the Ninth Circuit as the Providers argue CMS has seemed to recognize.[67] The hospitals in these group appeals are within the Ninth Circuit's jurisdiction, and thus the Providers argue that that decision is binding and remains in effect until the Supreme Court determines otherwise because the government did not request a stay of the decision pending Supreme Court review.[68] The Providers argue that if the Board believes it is bound by the Ninth Circuit's decision, the Providers request that the Board remand these cases to the MAC to recalculate all of the Providers' DSH payments consistent with the *Empire* ruling in which CMS' 2005 regulation was vacated and CMS' pre-2005 regulation under which only "covered" Part A days are treated as being "entitled to benefits under Part A" was reinstated.[69]

If instead, the Board believes it continues to be bound by CMS' 2005 regulation, and/or CMS Ruling 1498R, the Providers request that the Board grant EJR on this issue.[70]

IV. Decision of the Board

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

---

[65] *Becerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).
[66] EJR Request, at 1-3.
[67] *Id.* at 2-3, *citing* Pub. 100-09 Medicare Contractor Beneficiary and Provider Communications, Transmittal No. 11127 (Nov. 16, 2021) (calculating the 2019 SSI fractions for hospitals within the Ninth Circuit consistent with *Empire*); Transmittal No. 11276 (Feb. 24, 2022) (calculating the same for 2020).
[68] *Id.* at 1-3.
[69] *Id.*
[70] *Id.*

A. Jurisdiction for Appeals of Cost Report Periods Ending Prior to Dec. 31, 2008

The Providers in Case Nos. 14-3136GC(A) and 14-3136GC(B) have appealed cost reports with fiscal year ends ("FYEs") prior to December 31, 2008, namely, cost reports with FYEs of June 30, 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 an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen*.[71] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[72]

The Board has determined that the unpaid Medicare Dual Eligible Part A Days issues are governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. As such, since the Providers filed their cost reports in compliance with this regulation, they are not barred from claiming dissatisfaction with the amount of reimbursement allowed by the regulation and, in turn, challenging that regulation as part of these appeals.

In addition, the Providers' documentation for both Case Nos. 14-3136GC(A) and 14-3136GC(B) shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[73] The appeals were timely filed and no jurisdictional impediments for these issues have been identified. Finally, the Board notes that each Provider specifically included a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions in their respective individual appeals. Based on the foregoing, the Board finds that it has jurisdiction to conduct a hearing on the specific matter at issue in Case Nos. 14-3136GC(A) and 14-3136GC(B).

B. Jurisdiction for Appeals of Cost Report Periods Ending After Dec. 31, 2008 and Prior to January, 1, 2016

The Providers in Case Nos. 14-3482GC(A) and 14-3482GC(B) have appealed cost reports with FYEs of June 30, 2009.

---

[71] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[72] *Bethesda at 1258-59.*
[73] *See* 42 C.F.R. § 405.1837(a)(3).

1. Statutory and Regulatory Background

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[74] 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.[75]

On August 21, 2008, new regulations governing the Board were effective.[76] 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*").[77] 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.[78]

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

---

[74] 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.).
[75] *Bethesda*, 108 S. Ct. at 1258-59.
[76] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[77] 201 F. Supp. 3d 131 (D.D.C. 2016).
[78] *Id.* at 142.

2. Jurisdiction over Case Nos. 14-3482GC(A) and 14-3482GC(B) and the Underlying Participants

The Board has determined that the Exhausted Part A/Dual Eligible Days issues in the above-captioned CIRP group cases are governed by CMS Ruling CMS-1727-R since they are challenging the FY 2005 IPPS Final Rule and that Board review of the issues is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[79] The appeals were timely filed and no jurisdictional impediments have been identified for the remaining participants. Finally, the Board notes that each Provider specifically included a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions in their respective individual appeals. Based on the foregoing, the Board finds that it has jurisdiction to conduct a hearing on the specific matter at issue in Case Nos. 14-3482GC(A) and 14-3482GC(B).

C. Board's Analysis of the Appealed Issue

First, the Providers assert that the *Empire* ruling is binding for hospitals in the Ninth Circuit as the Providers argue that CMS has seemingly recognized that fact in CMS Transmittal No. 11127, which addresses the SSI/Medicare Beneficiary Data to be used in the calculation of DSH adjustments.[80] That transmittal directs Medicare Contractors to include only "covered days" in the SSI ratio, and provides as follows: "For IPPS hospitals in the Ninth Circuit's jurisdiction (Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon and Washington), these ratios include only "covered days" to reflect the decision of the 9th Circuit in Empire Health Foundation v. Azar (currently pending before the Supreme Court), to preliminarily settle cost reports."[81] However, that transmittal and the transmittal issued the following year to which the Providers cite, apply only for FY 2019 and FY 2020, respectively.[82] Importantly, the purpose of calculating those cost reports pursuant to *Empire* is to "preliminarily settle cost reports," and the transmittal notes that the Ninth Circuit's decision is currently pending before the Supreme Court. The cost reports at issue in this appeal have FYEs of June 30, 2008 and June 30, 2009, and thus those transmittals are not applicable to this appeal.

Further, 42 C.F.R. § 405.1867 specifies that "[i]n exercising its authority to conduct proceedings under this subpart, the Board **must** *comply with* all the provisions of Title XVIII of the Act and *regulations issued thereunder* . . . ."[83] Here the Secretary has not yet acquiesced to the Ninth Circuit's decision in *Empire* and has not otherwise retracted or revised the regulation at issue. Consequently, the Board finds that it continues to be bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Provider, namely: (1) invalidating the amendments

---

[79] *See* 42 C.F.R. § 405.1837.
[80] Transmittal No. 11127 (Nov. 16, 2021), and related MLN Matters Article No. MM12516, are available online at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r11127com.
[81] *Id.*
[82] *See id.*
[83] (Emphasis added.)

FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issues and fiscal years under appeal in these cases.

In making this finding, the Board notes that, as described above, the Providers maintained in their EJR Request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated, and such days should instead be counted in the patient days ratio of the Medicaid fraction (to the extent the days involve a dual eligible), and that this is consistent with the *Empire* ruling. However, as evidenced by the Ninth Circuit's decision in *Empire,* the invalidation of the DSH no-pay Part A days policy (as finalized in the FY 2005 IPPS Final Rule) does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that the Ninth Circuit's decision in *Empire* only reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i) under which no-pay Part A days were counted in neither the Medicare fraction nor the Medicaid fraction.

Moreover, it is clear that the situation in the instant case is not as simple as the one presented in *Allina Health Services v. Sebelius* ("*Allina*").[84] In *Allina*, the Ninth Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in *Allina* stated: "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[85]

In contrast, this case involves no-pay Part A days and the subset of no-pay Part A days associated with dual eligibles. It is clear that the *class of patients* who are dually eligible do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, with respect to this *patient class*, any days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction and included in the Medicaid fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits).[86] To this end, the Providers are asserting that only in *certain* ***no-pay*** Part A situations that involve a dual eligible beneficiary (*e.g.*, exhausted benefits and MSP) must the days associated with this class of patients be excluded from the SSI fraction and included in the Medicaid fraction.

Similarly, the class of patients who have Medicare Part A includes dual eligibles and that, with respect to this larger patient class, any days associated with them may not be excluded *in toto* (*i.e.*, it is undisputed that some Part A patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits). Significantly, under the Providers' desired interpretation of the DSH statute, any days associated with no-Pay Part A days for which the

---

[84] 746 F.3d 1102, 1108 (D.D. Cir. 2014).
[85] *Id.* (emphasis added).
[86] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina*, the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).

beneficiary was *not* Medicaid eligible (*i.e.*, the patient was not a dual eligible) would not be counted in either the Medicare or Medicaid fraction.

Accordingly, the Board disagrees with the Providers' position that exclusion of days associated with no-pay Part A situations where the underlying patient is a dual eligible *automatically* means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to: (1) the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*");[87] and (2) CMS Ruling 1498-R, wherein multiple possible treatments of no-pay dual eligible days are discussed and wherein CMS reconfirms that its policy prior to October 1, 2004 was to exclude all no-pay Part A days from the Medicare and Medicaid fractions even where the underlying patient was also eligible for Medicaid, stating:

> Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI Fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 C.F.R. 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changed to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098).[88]

Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Medical Center v. Blue Cross Blue Shield Association* ("*Edgewater*").[89] Thus, in the event the Supreme Court upholds the Ninth Circuit's decision in *Empire,* the Providers would be arguing that CMS' prior policy of excluding from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.

Accordingly, the Board continues to maintain that the Provider's legal argument for the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the Provider's legal argument for the "Medicaid

---

[87] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients.
[88] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.
[89] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater*").

Fraction/Dual Eligible Days" issue advocating inclusion of the subset of no-pay part A days that involve patients who are eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating the Providers' EJR Request as a consolidated request involving two separate issues – Dual Eligible, Non-Covered or Exhausted Part A Days in both the SSI and Medicaid fractions.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter at issue for the subject years and that the Providers in Case Nos. 14-3136GC(A), 14-3136GC(B), 14-3482GC(A) and 14-3482GC(B) are entitled to a hearing before the Board;

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

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

4) It is without authority to decide the legal question in Case Nos. 14-3136GC(A) and 14-3482GC(A) of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid and the legal question in Case Nos. 14-3136GC(B) and 14-3482GC(B) of what policy should then apply, namely whether to exclude or include such no-pay Part A days which involve a dual eligible from the Medicaid fraction if all no-pay Part A days are excluded from the Medicare fraction.

Accordingly, the Board finds that the questions in Finding 4 properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and grants the Providers' consolidated request for EJR for the issues and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. As there are no issues remaining in these appeals, the Board hereby closes them and removes them from the Board's docket.

Board Members Participating:

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

For the Board:

5/26/2022

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson C. Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Thomas Knight
Toyon Associates, Inc.
1800 Sutter St., Ste. 600
Concord, CA 94520-2546

RE: ***EJR Determination***
14-3996GC – *NorthBay Healthcare FY 2008 Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group*
14-4003GC – *NorthBay Healthcare FY 2009 Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group*

Dear Mr. Knight:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 29, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeals.[1] The decision of the Board is set forth below.

I. Issue in Dispute

These two groups were created after the Providers sought to transfer the issue in dispute from individual appeals with one group for 2008 and the other for 2009.[2] In the requests for group appeals, the Providers stated the issue in dispute, identically, as follows:

> NorthBay Healthcare (NBH) disputes the SSI percentage developed by [the Centers for Medicare & Medicaid Services ("CMS")] and utilized by the [Medicare Administrative Contractor ("MAC")] in their updated calculation of Medicare Inpatient Prospective Payment System DSH payment. On May 3, 2010 CMS published CMS Ruling 1498-R pertaining to three Medicare DSH issues, one of which requires the inclusion of Medicare Part A non-covered days (such as exhausted benefit days and Medicare secondary payer days) in the SSI ratio of the Medicare DSH . . . payment calculation[].
>
> NBH contends CMS' new interpretation of including Medicare Dual Eligible Part A Days in the SSI ratio issued on March 16, 2012 is tantamount to retroactive rule making, which the D.C.

[1] The Providers' Request for EJR also included Case No. 14-3998GC. However, the Board will address that case in a separate document under separate cover.
[2] Providers' Requests to Establish CIRP Group Appeal (both dated Aug. 18, 2014).

> Circuit held impermissible in the *Northeast Hospital* decision. The Secretary did not validly change her interpretation of the DSH calculation prior to FFY 2013, and because there is no statute that authorizes the Secretary to promulgate retroactive rules for DSH calculations, the Secretary cannot impose her new interpretation on the DSH payment calculation challenged in this case. NBH's position is supported by the federal district court decision in *Allina Health Services, et al, v. Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services* (Civil Action No. 10-1463 (RMC)). NBH maintains the position all unpaid Medicare Dual Eligible Part A Days should be included in the Medicaid patient day ratio of the Medicare DSH . . . payment calculation[].[3]

In the Providers' request for EJR, they frame the legal question as follows. The Providers, who are within the Ninth Circuit's jurisdiction, request a determination from the Board whether, in light of the Ninth Circuit's decision in *Empire Health Foundation for Valley Hospital Center v. Azar,* 958 F.3d 873 (9th Cir. 2020) ("*Empire*"), it has the authority to instruct the MAC to recalculate the Providers' DSH payments by no longer treating days that are not entitled to Part A payment as being "entitled to benefits under Part A" for purposes of both the Medicare and Medicaid DSH fractions.[4] If the Board determines it lacks that authority, the Board should grant EJR.[5] If the Board believes it has that authority by virtue of the Ninth Circuit's decision, it should remand to the MAC with instructions to recalculate the Providers' DSH payments by no longer treating days that are not entitled to Part A payment as nonetheless being "entitled to benefits under Part A" consistent with the ruling in *Empire*.[6]

Thus, it is clear from the Providers' issue statements that the Medicare Dual Eligible Part A Days in the SSI ratio issue impacts ***both*** the Medicare/SSI fraction and the Medicaid fraction of the DSH payment calculation. When framing issues for adjustments involving multiple components, Board Rule 8.1 requires that "each contested component must be appealed as a separate issue and described as narrowly as possible." Further, the statute and regulations governing group appeals specifically note that a provider has a right to a Board hearing as part of a group appeal with other providers "***only if*** . . . [t]he matter at issue in the group appeal involves a ***single*** question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group[.]"[7] Similarly, "[w]hen the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."[8] As discussed below in Section IV.B, the Board concludes that the Providers' challenge to the application of Dual Eligible , Non-Covered or

---

[3] *Id.* (emphasis in original).
[4] Request for Expedited Judicial Review, 1 (Apr. 29, 2022) ("EJR Request").
[5] *Id.*
[6] *Id.* at 1-2.
[7] 42 C.F.R. § 405.1837(a)(2). *See also* 42 U.S.C. 1395oo(b) (noting that a group appeal is proper "***only if*** the matters in controversy involve a common question of fact or interpretation of law or regulations . . .").
[8] 42 C.F.R. § 405.1837(f)(2)(ii).

Exhausted Part A Days in both the SSI and Medicaid fractions is two separate issues, even though they are identified in the Providers' appeal and EJR requests, and OH CDMS, as one combined issue. In this regard, the Board notes that it has historically required the formation of two separate groups for the Exhausted Part A Days issue as it relates to the SSI and Medicaid Fractions when the issue statement for the group request exclusion of no-pay Part A days from the SSI fraction and inclusion of the subset of those days involving dual eligible in the numerator of the Medicaid fraction.[9]

Since the Board has determined jurisdiction is proper for all participants of the two group appeals for both issues (as discussed in Section IV.A below), and for the sake of judicial economy, the Board is hereby bifurcating the two CIRP Group Appeals into the following cases, as reflected in the attached Schedules of Providers:

- 14-3996GC(A) – NorthBay Healthcare FY 2008 Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group/SSI Fraction
- 14-3996GC(B) – NorthBay Healthcare FY 2008 Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group/Medicaid fraction
- 14-4003GC(A) – NorthBay Healthcare FY 2009 Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group/SSI Fraction
- 14-4003GC(B) – NorthBay Healthcare FY 2009 Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group/Medicaid Fraction[10]

Accordingly, the Board is treating this EJR request as a consolidated EJR request to cover both issues, as discussed below.

II. Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[11] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[12]

---

[9] The Board also takes administrative notice that, when processing EJR requests on these two issues, it is correcting any limited situations where the Board may have previously consolidated these two issues in error.

[10] As these cases have the same record up to this point and there will be no further proceedings before the Board following this decision, the Board has opted for purposes of administrative efficiency not to create separate case numbers within OH-CDMS at this time. Should additional proceedings before the Board occur in these cases on remand to the Board, then the Board would do so at that time, as appropriate and relevant.

[11] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.

[12] *Id.*

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[13] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[14]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[15] 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.[16] The DPP is defined as the sum of two fractions expressed as percentages.[17] 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 . . . .[18]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[19]

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*

[13] *See* 42 U.S.C. § 1395ww(d)(5).
[14] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[15] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[16] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[17] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[18] (Emphasis added.)
[19] 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.[20]

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.[21]

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

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[22] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[23]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[24] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[25] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[26]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[27] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[28] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied

---

[20] (Emphasis added.)
[21] 42 C.F.R. § 412.106(b)(4).
[22] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.* at 27207-27208.
[27] *Id.* at 27207-08.
[28] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.

from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[29]

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

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

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[35] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

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

[29] 68 Fed. Reg. at 27208.
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[34] *Id.*
[35] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[36]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[37]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[38] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[39] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and

[36] 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004) (emphasis added).
[37] *Id.* at 49099 (emphasis added).
[38] *Id.*
[39] *See id.* at 49099, 49246.

> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[40]

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

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

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

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[43] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a

[40] (Emphasis added.)
[41] (Emphasis added.)
[42] *Id.*
[43] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days are only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).

> practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[44]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[45] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[46] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[47] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[48] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[49] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[50] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp. v. Sebelius*,[51] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[52]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[53] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[54] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[55] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before

---

[44] (Citations omitted and emphasis added.)
[45] 317 F. Supp. 3d 168 (D.D.C. 2018).
[46] *Id.* at 172.
[47] *Id.* at 190.
[48] *Id.* at 194.
[49] *See* 2019 WL 668282.
[50] 718 F.3d 914 (2013).
[51] 657 F.3d 1 (D.C. Cir. 2011).
[52] 718 F.3d at 920.
[53] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[54] *Id.* at 1141.
[55] *Id.*

the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[56] and that the regulation is procedurally invalid.[57]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[58] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[59] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[60] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[61] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[62] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[63] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[64] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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

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

---

[56] *Id.* at 1162.
[57] *Id.* at 1163
[58] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[59] *Id.* at 884.
[60] *Id.* at 884.
[61] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[62] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[63] *Id.* at 886.
[64] *Id.*

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[65] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

III. Providers' Position

The Providers are challenging the inclusion of certain non-covered (Part A exhausted or Medicare secondary payor) patient days in the Medicare (or SSI) fraction.[66] The Providers believe that the Ninth Circuit's decision in *Empire* entirely vacates the Secretary's 2005 Rule, discussed above, on a nationwide basis and that, at a minimum, the *Empire* ruling is binding for hospitals in the Ninth Circuit as the Providers argue CMS has seemed to recognize.[67] The hospitals in these group appeals are within the Ninth Circuit's jurisdiction, and thus the Providers argue that that decision is binding and remains in effect until the Supreme Court determines otherwise because the government did not request a stay of the decision pending Supreme Court review.[68] The Providers argue that if the Board believes it is bound by the Ninth Circuit's decision, the Providers request that the Board remand these cases to the MAC to recalculate all of the Providers' DSH payments consistent with the *Empire* ruling in which CMS' 2005 regulation was vacated and CMS' pre-2005 regulation under which only "covered" Part A days are treated as being "entitled to benefits under Part A" was reinstated.[69]

If instead, the Board believes it continues to be bound by CMS' 2005 regulation, and/or CMS Ruling 1498R, the Providers request that the Board grant EJR on this issue.[70]

IV. Decision of the Board

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

---

[65] *Becerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).
[66] EJR Request, at 1-3.
[67] *Id.* at 2-3, *citing* Pub. 100-09 Medicare Contractor Beneficiary and Provider Communications, Transmittal No. 11127 (Nov. 16, 2021) (calculating the 2019 SSI fractions for hospitals within the Ninth Circuit consistent with *Empire*); Transmittal No. 11276 (Feb. 24, 2022) (calculating the same for 2020).
[68] *Id.* at 1-3.
[69] *Id.*
[70] *Id.*

A. Jurisdiction for Appeals of Cost Report Periods Ending On or After Dec. 31, 2008 and Prior to January, 1, 2016

The Providers in Case Nos. 14-3996GC(A) and 14-3996GC(B) have appealed cost reports with FYEs of December 31, 2008. The Providers in Case Nos. 14-4003GC(A) and 14-4003GC(B) have appealed cost reports with FYEs of December 31, 2009.

1. Statutory and Regulatory Background

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[71] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[72]

On August 21, 2008, new regulations governing the Board were effective.[73] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[74] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[75]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor

---

[71] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[72] *Bethesda*, 108 S. Ct. at 1258-59.
[73] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[74] 201 F. Supp. 3d 131 (D.D.C. 2016).
[75] *Id.* at 142.

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.

2. Jurisdiction over Case Nos. 14-3996GC(A), 14-3996GC(B), 14-4003GC(A) and 14-4003GC(B) and the Underlying Participants

The Board has determined that the Exhausted Part A/Dual Eligible Days issues in the above-captioned CIRP group cases are governed by CMS Ruling CMS-1727-R since they are challenging the FY 2005 IPPS Final Rule and that Board review of the issues is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[76] The appeals were timely filed and no jurisdictional impediments have been identified for the remaining participants. Finally, the Board notes that each Provider specifically included a challenge to the application of Dual Eligible, Non-Covered or Exhausted Part A Days in ***both*** the SSI and Medicaid fractions in their respective individual appeals. Based on the foregoing, the Board finds that it has jurisdiction to conduct a hearing on the specific matter at issue in Case Nos. 14-3996GC(A), 14-3996GC(B), 14-4003GC(A) and 14-4003GC(B).

B. Board's Analysis of the Appealed Issue

First, the Providers assert that the *Empire* ruling is binding for hospitals in the Ninth Circuit as the Providers argue that CMS has seemingly recognized that fact in CMS Transmittal No. 11127, which addresses the SSI/Medicare Beneficiary Data to be used in the calculation of DSH adjustments.[77] That transmittal directs Medicare Contractors to include only "covered days" in the SSI ratio, and provides as follows: "For IPPS hospitals in the Ninth Circuit's jurisdiction (Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon and Washington), these ratios include only "covered days" to reflect the decision of the 9th Circuit in Empire Health Foundation v. Azar (currently pending before the Supreme Court), to preliminarily settle cost reports."[78] However, that transmittal and the transmittal issued the following year to which the Providers cite, apply only for FY 2019 and FY 2020, respectively.[79] Importantly, the purpose of calculating those cost reports pursuant to *Empire* is to "preliminarily settle cost reports," and the transmittal notes that the Ninth Circuit's decision is currently pending before the Supreme Court. The cost reports at issue in this appeal have FYEs of December 31, 2008 and December 31, 2009, and thus those transmittals are not applicable to this appeal.

Further, 42 C.F.R. § 405.1867 specifies that "[i]n exercising its authority to conduct proceedings under this subpart, the Board **must** *comply with* all the provisions of Title XVIII of the Act and

---

[76] *See* 42 C.F.R. § 405.1837.
[77] Transmittal No. 11127 (Nov. 16, 2021), and related MLN Matters Article No. MM12516, are available online at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r11127com.
[78] *Id.*
[79] *See id.*

regulations issued thereunder . . . ."[80] Here the Secretary has not yet acquiesced to the Ninth Circuit's decision in *Empire* and has not otherwise retracted or revised the regulation at issue. Consequently, the Board finds that it continues to be bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Provider, namely: (1) invalidating the amendments FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issues and fiscal years under appeal in these cases.

In making this finding, the Board notes that, as described above, the Providers maintained in their EJR Request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated, and such days should instead be counted in the patient days ratio of the Medicaid fraction (to the extent the days involve a dual eligible), and that this is consistent with the *Empire* ruling. However, as evidenced by the Ninth Circuit's decision in *Empire,* the invalidation of the DSH no-pay Part A days policy (as finalized in the FY 2005 IPPS Final Rule) does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that the Ninth Circuit's decision in *Empire* only reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i) under which no-pay Part A days were counted in neither the Medicare fraction nor the Medicaid fraction.

Moreover, it is clear that the situation in the instant case is not as simple as the one presented in *Allina Health Services v. Sebelius* ("*Allina*").[81] In *Allina*, the Ninth Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in *Allina* stated: "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[82]

In contrast, this case involves no-pay Part A days and the subset of no-pay Part A days associated with dual eligibles. It is clear that the *class of patients* who are dually eligible do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, with respect to this *patient class*, any days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction and included in the Medicaid fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits).[83] To this end, the Providers are asserting that only in *certain* ***no-pay*** Part A situations that involve a dual eligible beneficiary (*e.g.*, exhausted benefits and MSP)

---

[80] (Emphasis added.)
[81] 746 F.3d 1102, 1108 (D.D. Cir. 2014).
[82] *Id.* (emphasis added).
[83] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina*, the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).

must the days associated with this class of patients be excluded from the SSI fraction and included in the Medicaid fraction.

Similarly, the class of patients who have Medicare Part A includes dual eligibles and that, with respect to this larger patient class, any days associated with them may not be excluded *in toto* (*i.e.*, it is undisputed that some Part A patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits). Significantly, under the Providers' desired interpretation of the DSH statute, any days associated with no-Pay Part A days for which the beneficiary was *not* Medicaid eligible (*i.e.*, the patient was not a dual eligible) would not be counted in either the Medicare or Medicaid fraction.

Accordingly, the Board disagrees with the Providers' position that exclusion of days associated with no-pay Part A situations where the underlying patient is a dual eligible *automatically* means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to: (1) the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*");[84] and (2) CMS Ruling 1498-R, wherein multiple possible treatments of no-pay dual eligible days are discussed and wherein CMS reconfirms that its policy prior to October 1, 2004 was to exclude all no-pay Part A days from the Medicare and Medicaid fractions even where the underlying patient was also eligible for Medicaid, stating:

> Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI Fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 C.F.R. 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changed to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098).[85]

Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Medical Center v. Blue Cross Blue Shield Association* ("*Edgewater*").[86] Thus, in the

---

[84] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients.
[85] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.
[86] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the

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

Accordingly, the Board continues to maintain that the Provider's legal argument for the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the Provider's legal argument for the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the subset of no-pay part A days that involve patients who are eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating the Providers' EJR Request as a consolidated request involving two separate issues – Dual Eligible, Non-Covered or Exhausted Part A Days in both the SSI and Medicaid fractions.

C. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter at issue for the subject years and that the Providers in Case Nos. 14-3996GC(A), 14-3996GC(B), 14-4003GC(A) and 14-4003GC(B) are entitled to a hearing before the Board;

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

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

4) It is without authority to decide the legal question in Case Nos. 14-3996GC(A) and 14-4003GC(A) of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid and the legal question in Case Nos. 14-3996GC(B) and 14-4003GC(B) of what policy should then apply, namely whether to exclude or include such no-pay Part A days which involve a dual eligible from the Medicaid fraction if all no-pay Part A days are excluded from the Medicare fraction.

Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater*").

Accordingly, the Board finds that the questions in Finding 4 properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and grants the Providers' consolidated request for EJR for the issues and the subject years.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. As there are no issues remaining in these appeals, the Board hereby closes them and removes them from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

5/26/2022

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson C. Leong, FSS