DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
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June 4, 2021

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Pamela VanArsdale
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RE: Dismissal of Case 20-1171GC
Centegra Health FFY 2020 ATRA IPPS Payment Reduction CIRP Group
PRRB Case Number: 20-1171GC

Dear Mr. Ramanathan and Ms. VanArsdale:

In a letter dated April 7, 2021, the Provider Reimbursement Review Board ("the Board") required that Quality Reimbursement Services, Inc. ("QRS") provide information with regard to the participation of Northern Illinois Medical Center (14-0176) ("NIMC") in the subject group appeal. In its April 7, 2021 correspondence, the Board advised that NIMC was already a participant in another common issue related party ("CIRP") group appeal for the ATRA IPPS Payment Reduction issue (Case No. 20-0592GC) which was filed by Hall Render Killian Heath & Lyman ("Hall Render"). Therefore, the Board required that QRS either withdraw NIMC from the subject group or that it provide an explanation of why the group should remain pending. QRS' response was due to the Board on April 23, 2021. On May 17, 2021, QRS filed a request for an extension asking for an additional 15 days to respond to the Board's correspondence because "QRS has been coordinating with the provider who in turn has been working to determine how the various representatives should work together." The Board's April 7, 2021 letter was clear that "failure of QRS to make the requisite filing within the specified timeframe will result in the Board dismissing the Provider and closing Case No. 20-1171GC." Further, although the Board did not formally respond to QRS' extension request, which was filed almost a month after the original deadline, the stated reason for the requested extension does NOT relate to information requested by the Board and the 15-day extension period requested has now expired as well. Because the information required in the Board's April 7, 2021 correspondence was not submitted, the Board is taking the actions laid out its April 7, 2020 letter and hereby dismisses Case No. 20-1171GC.

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

FOR THE BOARD:

Clayton J. Nix, Esq.
Chair

cc: Wilson C. Leong, Federal Specialized Services
Elizabeth Elias, Hall, Render, Killian, Heath & Lyman, PC

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Via Electronic Delivery

Maureen O'Brien Griffin, Esq.
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RE: ***Jurisdictional and EJR Determination***
Hillsdale Community Health Center (Prov. No. 23-0037)
FYEs 6/30/09, 6/30/10
Case Nos. 14-0761, 14-0762

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's May 5, 2021 request for expedited judicial review ("EJR Request") regarding the above-referenced cases involving Hillsdale Community Health Center (Prov. No. 23-0037) and its fiscal years ending June 30, 2009 and June 30, 2010 ("FYs 2009 and 2010"). The Board's determination regarding the EJR Request is set forth below.

Issue in Dispute as Described in the EJR Request:

The issue for which EJR has been requested in Case Nos. 14-0761 and 14-0762 is:

> The days at issue in these appeals are days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in these appeals . . . is whether the intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction" for purposes of calculating [the Provider's] [Disproportionate Share Hospital ("DSH")] payment, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."
>
> [The Provider] respectfully asserts that under the rules of statutory construction [the Centers for Medicare and Medicaid Services ("CMS")] is compelled to *interpret* ***"entitlement to SSI"*** *benefits to include* ***all*** *inpatients who were* ***eligible for and/or enrolled in the SSI program at the time of their hospitalization*** *and, further, to furnish [the Provider] with a listing of those SSI Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare Act*. Furthermore, [the Provider] seeks a ruling that CMS has failed to provide [the Provider] with adequate information to allow them to check and challenge CMS's

> disproportionate patient percentage ("DPP") calculations. [The Provider] is entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173 . . . . Because *the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS* instead of the full list of Medicare patients who are enrolled in SSI and/or eligible for SSI benefits along with their corresponding SSI status codes, and does not give [the Provider] any meaningful means of challenging the SSI days chosen by CMS to be used in [the Provider's] DPP calculations, CMS continually *violates its § 951 mandate*.[1]

Thus, the issues presented in the EJR request relate to the interpretation of "entitlement to SSI" where the Provider alleges that CMS improperly limits that interpretation to 3 SSI patient service codes ("SSI PSCs") and that CMS violates MMA § 951 by improperly limiting the SSI days summary data to 3 SSI PSCs. The Board will refer to these EJR issues as the "SSI Entitlement Issues."

Board's Authority:

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) 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.

Procedural Background:

On November 13, 2013, the Provider filed its request for hearing ("RFH") for FY 2009 based on a May 20, 2013 Notice of Program Reimbursement ("NPR"). Similarly, on November 14, 2013, the Provider filed its RFH for FY 2010 based on an NPR dated August 2, 2013. The Board assigned the FY 2009 appeal to Case No. 14-0761 and the FY 2010 appeal to Case No. 14-0762. In each case, the Provider's designated representative was Plante Moran, PLLC ("Plante Moran").

On November 18, 2014, Plante Moran filed a preliminary position paper ("PPP") in each of these cases. Subsequently, in April 2020, the Provider changed its authorized representative in each of these cases from Plante Moran to Hall, Render, Killan, Heath & Lyman, P.C. ("Hall Render"). On March 16, 2021, Hall Render filed a final position paper ("FPP") in each of these cases

[1] Provider's EJR Request at 2 (emphasis added).

A. Jurisdictional Challenge

On March 31, 2021, the Medicare Contractor filed Jurisdictional Challenges in both Case Nos. 14-0761 and 14-0762. The Medicare Contractor has challenged the Board's jurisdiction over:

- Issue 2, exhausted benefit days, claiming that the Provider abandonned the issue in the FPPs;[2] and
- Issue 4, the SSI percentage, claiming that this was a *Baystate* SSI Data Accuracy issue and that the Provider abandoned the issue when it filed its FPPs by failing to submit evidence to establish the material facts in the case related to the SSI percentage.[3]

Further, the Medicare Contractor asserts that the Provider improperly attempted to add the SSI Entitlement Issues since the time to add issues had tolled.[4]

B. The Provider's Response

The Provider responded by arguing that its RFHs demonstrated dissatisfaction with its Medicare Fraction and it "has claimed each step of the way" that "its Medicare Fraction is inaccurate and incomplete."[5] The Provider asserts that: "[c]entral to this assertion of incompleteness is a belief that the 3 PSC codes [*i.e.,* patient service codes] are incomplete in terms of capturing the correct number of SSI enrollees in the numerator of the Medicare Fraction."[6]

The Provider references its RFHs as sufficient to appeal the issue and asserts that it "expressed clear dissatisfaction with the exclusion of SSI patient days from the numerator of its Medicare fraction."[7] The Provider believes the Supreme Court decision in *Bethesda* only requires that a provider's appeal request express dissatisfaction with its reimbursement on the cost report.[8]

Further, the Provider contends that it has neither improperly added the SSI Entitlement Issues as stated in the EJR request nor abandoned its original Issue 4, the SSI eligible days issue. First, the Provider asserts that the language of its RFHs "does not box the Provider into a matching argument like *Baystate*."[9] The Provider then asserts that, when compared to the RFHs, its PPPs

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[2] Jurisdictional Challenge at 2-3.
[3] *Id.* at 3-4 (stating that "the MAC contends that the Provider abandoned the Baystate SSI Data Accuracy issue when it failed to properly develop the issue, set forth the merits of its claim and provide documents and analysis to support its position in its final position paper in accordance with Board Rules 27.2, 25 and 42 C.F.R. § 405.1853(b)(2)"; rather, "The majority of the [FPP] was focused squarely on an entirely new issue contesting the Center for Medicare and Medicaid Services' ("CMS") interpretation of the DSH formula as set forth in 42 U.S.C. § 13955ww(d)(5)(F)(vi) ("DSH Statute")").
[4] *Id.* at 4.
[5] Provider's Response to the Jurisdictional Challenge at 4.
[6] *Id.*
[7] *Id.*
[8] *Id.* at 4-7.
[9] *Id.* at 7.

contain "nearly identical language" for this issue.[10] After quoting that "nearly identical language" from the PPPs, the Provider asserts that "[t]his **brief** argument is not limited to the data match issue that was prominent in *Baystate*,"[11] but rather, that the Provider "specifically gives *Baystate* as an example of its position, implying this is not the only support for its position."[12]

The Provider makes a similar argument about the language in the PPPs which states that the DSH adjustment was "inaccurate and/or incomplete."[13] The Provider asserts that "[t]his, too, does not limit [*sic* the] Provider to the fact pattern in *Baystate*—describing something as incomplete clearly indicates that category of data is be [*sic*] missing."[14]

In addition, the Provider cites to the **Administrator's** decision in *Baystate* to support its assertion that "*Baystate* raised a number of the same SSI-days issues raised and discussed by [*sic* the] Provider regarding inaccuracies and/or incompleteness of certain types/categories of SSI-days being wrongfully excluded, such as omission of non-cash SSI benefits, omission of hold and suspense categories because the patient moved or their representative payee changed, all of which stem from CMS's incorrect interpretation of 'SSI entitlement' in the DSH statute."[15] The Provider then argues that "[i]t is inaccurate to Characterizing [*sic* characterize] *Baystate* as only being representative of matching mistakes where patients were missed is improper."[16] The Provider concludes the argument by asserting that "[a]ny SSI appeal which states the MAC 'erred in calculating the [SSI] percentage . . .' encompasses all and any potential inaccuracies, incompleteness of certain types of SSI-days, and other errors or improprieties with respect to how CMS counted SSI-days."[17]

Finally, the Provider points out that the Amount in Controversy section of the Issue Statement in its RFHs state that "[t]he documents or data relating to CMS' calculation of the DSH payment that were utilized in CMS's calculation as required by DSH, to the best of [*sic* the] Provider's knowledge, solely in possession of CMS."[18] The Provider then asserts that it "has ***consistently*** claimed that it lacks access to data that would help assert its theory."[19] Further, the Provider asserts that it "obtained the DSH data it is permitted to obtain from CMS" and that this data does not provide the PSC codes and does not "tell a provider what patients may have been erroneously excluded from the three PSC codes the agency uses." Accordingly, the Provider asserts that "the burden of proof needs to switch to the MAC/CMS to prove the SSI Fraction at issue is supported by substantial evidence" and that "CMS needs to disclose what data it sued and why."[20]

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[10] *Id.*
[11] *Id.* (bold and underline emphasis added).
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.* 7-8.
[18] *Id.* at 8.
[19] *Id.* (emphasis added).
[20] *Id.*

C. The Appeals

For both FY 2009 appeal (Case No. 14-0761) and the FY 2010 appeal (Case No. 14-0762), the following four (4) issues were appealed:

1. Medicare Advantage Days;
2. Medicaid Fraction-Exhausted Days;
3. Medicare Fraction-Medicare Advantage Days; and
4. Medicare Fraction-SSI Percentage.

In both cases, on May 7, 2020, the Provider transferred two Part C days issues to groups. *As a result, there are only two issues remaining in these two appeals, namely Issues 2 and 4.* Specifically, in the FY 2009 appeal (Case No. 14-0761), the Provider transferred the Medicare Advantage days issues to Case No. 20-1647G identifying the adjustments for the issues as Audit Adjustment Nos. 38 and 39; however, the hearing request identifies the adjustments appealed as Audit Adjustment Nos. 35 and 36. In the FY 2010 appeal (Case No. 14-0762), the Provider transferred two Medicare Advantage days issues to Case No. 20-0170G, identifying the adjustments as Audit Adjustment Nos. 38 and 39 (although Audit Adjustment Nos. 35 and 36 had been appealed).

Importantly, in both Case Nos. 14-0761 and 14-0762, Plante Moran was the Provider's original designated representative and the RFHs filed by Plante Moran in these cases uses the ***same*** identical language to describe Issues 2 and 4. Specifically, for both cases, the Provider gave the following description for Issue 2 in its RFHs which sought to move certain days from the SSI fraction *to the **Medicaid** fraction*:

> **Medicaid Fraction – Exhausted Days**
>
> Statement of the Issue:
>
> The intermediary erred *by incorrectly omitting* days attributable to patients whose benefits were exhausted for Medicare Part A which Medicare Part A did not make payment and were dual eligible for Medicaid and Medicare for purposes of the calculation of the providers disproportionate share payment.
>
> Brief Description of the Issues:
>
> The Provider believes the Intermediary's calculation of the Provider's Medicare [DSH] payments improperly excluded "exhausted benefit days" in the Medicaid fraction numerator. These would include days attributable to patients whose benefits were exhausted for Medicare Part A which Medicare Part A did not make payment and where the

> patient was dually eligible for Medicaid and Medicare as described in 42 U.S.C. § 1395ww(d)(5(F)(vi)(II) and 42 C.F.R. § 412.106(b).
>
> ****
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> Amount in Controversy:
>
> The Provider believes that its DSH reimbursement *should correctly adjust the "Medicaid fraction" to include days* attributable to patients who benefits were exhausted for Medicare Part A which Medicare Part A did not make payment and where the patient was dual eligible for Medicaid and Medicare. The correct value of this correct adjustment is not able to be fully calculated from the information currently available to the provider, but is in excess of $10,000. The documents or data relating to the calculation of the adjustment to the DSH payment are, to the best of the Provider's knowledge, in the possession of CMS.
>
> Legal Basis for the Appeal:
>
> The Provider believes that the inclusion of the requested days for purposes of the [DSH] payment is supported by the plain language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).[21]

For both cases, the Provider gave the following description for Issue 4 in its RFHs which sought to correct certain unspecified "errors" in the SSI fraction:

> **Medicare Fraction – SSI Percentage**
>
> Statement of the Issue:
>
> The intermediary *erred* by incorrectly calculating the SSI percentage for inclusion in the "Medicare Fraction" for purposes of the calculation of the provider's [DSH] payment.
>
> Brief Description of the Issues:
>
> The Provider believes the Intermediary's calculation of the Providers' Medicare [DSH] payments *contains errors* in the calculation of the SSI percentage for purposes of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).
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> * * *

[21] (Underline and bold emphasis in original and italics emphasis added.)

> Amount in Controversy:
>
> The Provider believes that its DSH reimbursement *should correctly reflect an accurate SSI percentage* for purposes of the "Medicare fraction". The correct value of this adjustment is not able to be fully calculated from the information currently available to the provider, but is in excess of $10,000. The documents or data relating to CMS's calculation of the adjustment to the DSH payment that were utilized in CMS's calculation as required by DSH are, to the best of the Provider's knowledge, solely in the possession of CMS.
>
> Legal Basis for Appeal:
>
> The Provider believes that *inclusion of correct data* and calculation of the SSI percentage for purposes of the [DSH] payment is supported by the plain language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).[22]

On November 18, 2014, Plante Moran filed the Provider's PPPs in Case Nos. 14-0761 and 14-0762 and briefed Issue 2, the Medicaid fraction exhausted days issue, as well as Issue 4, the SSI percentage issue. In the PPPs filed for these cases, the Provider described Issue 2 as:

> **(ISSUE 2) THE INTERMEDIARY ERRED WHEN IT OMITTED FROM THE PROVIDER'S "MEDICAID FRACTION" DAYS ATTRIBUTABLE TO PATIENTS WHO WERE DUALLY ELIGIBLE FOR MEDICARE PART A AND MEDICAID, BUT WHOSE MEDICARE PART A BENEFITS WERE EXHAUSTED WHEN IT CALCULATED THE PROVIDER'S DSH PAYMENT. (AUDIT ADJUSTMENTS 38 & 39)**
>
> Once again, the plain language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) indicates that in order to properly determine the Provider's Medicaid fraction the total number of patient days attributable to patients eligible for Medicaid but not entitled to benefits under Medicare Part A should be included in the numerator. Here, the Intermediary improperly excluded patients whose benefits had been exhausted under Medicare Part A that were also eligible for Medicaid from the Provider's Medicaid fraction. As a result of the Intermediary's erroneous adjustment, the Provider was denied reimbursement to which it was entitled to receive.

[22] (Underline and bold emphasis in original and italics emphasis added.)

> The key determination with respect to this issue is whether patients that have exhausted their right to receive benefits under Medicare Part A remain "entitled" to benefits under Part A. As discussed above, the only benefit to which a Medicare Part A beneficiary is entitled, is the benefit to have payments for medical services made on the beneficiary's behalf. When a Medicare Part A beneficiary has exhausted their right to have payments made on their behalf, there remains no entitlement to benefits under Medicare Part A. This interpretation is supported by the Medicare statute. The statute defines entitlement to benefits under Medicare Part A as the right to have payment made on the patient's behalf for covered services. 42 U.S.C. § 1395d(a).
>
> When presented with this issue previously, the Board determined that such "Medicare exhaust days" should have been included in the provider's Medicaid fraction. *Allina Health System v. Blue Cross Blue Shield Association*, PRRB Dec. No. 2009-D35 (July 30, 2009); *rev'd. by CMS Administrator Decision* (Sept. 21, 2009) CCH ¶82,426.
>
> When individuals that are also eligible for Medicaid have exhausted their benefits under Medicare Part A, based upon the plain language of the applicable statute, <u>such days should be included in the provider's Medicaid fraction</u> as those individuals are no longer entitled to benefits under Medicare Part A. Those days were excluded from the Provider's Medicaid fraction in this case, and such exclusion was impermissible and should be reversed.[23]

In addition, in the PPPs filed for these cases, the Provider described Issue 4 as:

> **(ISSUE 4) THE INTERMEDIARY ERRED WHEN IT INCORRECTLY CALCULATED THE PROVIDER'S SSI PERCENTAGE IN THE PROVIDER'S "MEDICARE FRACTION" FOR PURPOSES OF CALCULATING THE PROVIDER'S DSH ADJUSTMENT (AUDIT ADJUSTMENTS 38 & 39)**
>
> The Provider believes the Intermediary and/or CMS <u>erred</u> in its calculation of the SSI percentage and its application to this Provider. The propriety of the SSI percentage calculation has been, and continues to be, the subject of considerable litigation. For

[23] Provider's PPPs at 9-10 (underline emphasis added and footnote omitted.)

> example, the Board ruled on this specific issue in a case styled *Baystate Medical Center v. Mutual of Omaha Insurance Company*, PRRB Dec. No. 2006-D20 (March 17, 2006; *rev'd by CMS Administrator Decision* (May 11, 2006) CCH ¶81,506. On March 31, 2008, the United States District Court for the District of Columbia reversed the Administrator's decision and found, like the Board below, that there were errors in the SSI percentage which CMS was directed to correct. *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.C.C. 2008). The Provider believes there remains errors in the calculation of its SSI percentage that adversely affect its DSH reimbursement.
>
> Therefore, the Provider has appealed the calculation used by the Intermediary in determining the Provider's DSH adjustment believing the same to be inaccurate and/or incomplete. Because the calculation used by the Intermediary was improper, the Provider's DSH calculation is incorrect and the Provider requests that the same be corrected.[24]

Subsequently, on March 16, 2021, the Provider's new representative, Hall Render, filed the Provider's FPPs for both cases. Both FPPs failed to brief Issue 2, the exhausted days issue, but did brief Issue 4, the SSI percentage issue. Specifically, the FPP only discusses a single issue, Issue 4. In this regard, the FPPs restate word-for-word the description it made for Issue 4 in the RFHs for Issue 4 (*i.e.*, it states verbatim the statement of the issue, the brief description of the issues, the amount in controversy and legal basis for appeal included in the RFHs for Issue 4).

In the introduction to the Provider's arguments in its FPPs, the Provider states that that, as discussed in both its RFHs and its PPPs, the Provider "believes *errors* exist in the calculation of its Medicare SSI fraction" and that the Provider "clearly did not *limit* the types and/or number of *errors* it was appealing." The Provider alleges that "these *errors* involve CMS' erroneous and inadequate implementation of the revised data match process in which days are missed due to various deficiencies such as inadequate unique identifiers, and other issues not fully corrected by CMS pursuant to CMS Ruling 1498-R (hereinafter 'mechanical implementation errors')" and that "these errors involve the types of SSI days CMS includes in and/or excludes from the data match process stemming from their erroneous and mistaken implementation of the DSH statute (hereinafter 'statutory interpretation errors') . . . ."[25] *The Provider maintains that its RFHs contemplated both mechanical implementation errors **and** statutory interpretation errors*.

The FPPs then devote roughly 30 pages to briefing the following "Arguments" related to Issue 4:

> A. CMS Has Conceded That It Systematically Excludes Many Categories of SSI Eligible Individuals from the Medicare Fraction

[24] Provider's PPPs at 12 (underline emphasis added).
[25] *Id. at 4.*

Numerator, and Alternative Proxies such as Dual Eligible Days and Published SSI Data Illustrate the Magnitude of the Agency's Erroneous Actions on the Provider.

B. The Agency's Matching Choices have a Profoundly Negative Impact on Providers' DSH Reimbursement.

C. SSI Eligibility Data Must Be Produced By the MAC/CMS, Not the Provider.

D. CMS Violated the Plain Language of the DSH Statute by Adopting Conflicting Interpretations of the Term "Entitled To Benefits" With Respect to Part A and SSI; Therefore, Its Interpretation Fails Under Step One of Chevron.

1. Despite Congress's Clear Intent, CMS Does Not Consistently Interpret and Apply the Term "Entitled to Benefits."

2. CMS's Matching Process is flawed because it *only uses Three SSI Status Codes*, a Violation of the DSH Statute.

E. The Agency's Categorical Exclusion of SSI Eligible Individuals' Inpatient Days from the Medicare Fraction Numerator Conflicts with Congress's Express Intent to Capture SSI Eligible Patients Who Are Medicare Beneficiaries in the Medicare Fraction Numerator; Therefore, the Agency's Narrow Construction of "Entitled to Supplemental Security Income Benefits" Fails Under Chevron Step One.

F. The Agency's Construction and Interpretation of the DSH Statute Leads to Results so Absurd That the Interpretation Cannot Be Ascribed to a Difference in Opinion or Agency Expertise; Therefore, It Is Arbitrary and Capricious Under Chevron Step Two.

G. Since the PRRB is Bound by CMS Rules and Policy, it Does Not Have the Authority to Decide the Issues Raised by the Provider in this DSH Appeal, and Therefore the Only Proper Action by the Board Here is to Determine that this Appeal Should Receive Expedited Judicial Review.[26]

As illustrated by the above, the bulk of the FPPs focues on a statutory interpretation error that relates to how CMS uses only 3 of the 77 SSI PSCs to determine which patients were "entitled"

[26] (Emphasis added.)

to SSI benefits at the time of their hospital care and that result in CMS allegedly improperly excluding many categories of SSI eligible beneficiaries (as represented by SSI PSCs) from the SSI fraction of the Medicare fraction of the DSH adjustment.[27] The Provider believes that additional PSCs should be used to determine SSI "entitlement." The Provider also notes that the Board does not have the authority to order CMS or the MAC to provide the Provider with the remedy it seeks, consequently, the Board should grant the Provider's request for EJR.[28]

The Board's Analysis, Findings of Fact and Conclusions of Law:

As noted *supra*, the Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842 (2019). Under the implementing regulations, the Board is required to grant a provider's EJR request if it determines that: (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue (as described in 42 C.F.R. § 405.1840); and (2) 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. Further, 42 C.F.R.§ 405.1842(e)(1) states, in relevant part: "If the Board makes a finding that it has jurisdiction to conduct a hearing on a specific matter at issue in accordance with § 405.1840 . . . then (and only then) it must consider whether it lacks the authority to decide a legal question relevant to the matter at issue." Accordingly, a Board finding of jurisdiction is a *prerequisite* to any review of an EJR request.

Under 42 C.F.R. § 405.1840(b), the Board has jurisdiction to grant a hearing over a *specific* matter at issue in an appeal *only if* the provider has a right to a Board hearing as a single provider appeal under § 405.1835. The regulation at 42 C.F.R. § 405.1835 describes the right to a Board hearing in subsection (a) and the content requirements of a hearing request in subsection (b). A provider's written hearing request *must* include certain elements. More specifically, under 42 C.F.R. § 405.1835(b)(2) (2013), a provider's written request for hearing must contain, "*for each **specific** item at issue,"* a separate explanation of why, and a description of how, the provider is dissatisfied with the *specific* aspects of the final determination under appeal:

> (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 paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss with prejudice the appeal, or take any other remedial action it considers appropriate. . . .

[27] In this regard, the Provider's FPPs state: "The main issue is ***not*** the matching process . . . – the main issue is the data CMS has chosen to use to calculate payments. There are 77 PSC codes, but CMS chooses to only use three. The Provider is stuck with the three codes CMS uses, and must rely on CMS to explain why the remaining 74 are not utilized." Provider's FPPs at 36.
[28] *Id. at 40.*

> (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**.[29]

Accordingly, the regulations prescribe that if a provider submits a hearing request that *does not* meet the requirements of (b)(1), (2), or (3), the Board may dismiss the appeal with prejudice or take any other remedial action it considers appropriate.[30]

In keeping with the above-quoted regulation's specificity requirement, the Board's Rules in effect at the time that the Provider filed its RFHs stated the following:

> **Rule 8—Framing Issues for Ajdustment 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 issue and described <u>*as narrowly*</u> as possible using the applicable format outlined in Rule 7. See common examples below.
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> **8.2 – Disproportionate Share Cases** (e.g., dual eligible, general assistance, charity care, HMO days, etc.)[31]

In addition, with respect to a party's PPP, the Board Rules include the following commentary:

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[29] (Bold emphasis added.)
[30] 42 C.F.R. § 405.1835(b).
[31] Board Rule 8 (March 1, 2013 & July 1, 2015) (italics and underline emphasis added).

> **COMMENTARY**: Under the Regulations effective August 21, 2008, all issues will have been identified well in advance of the due date for preliminary position papers. Unlike the prior practice, preliminary position papers now are expected to present *fully developed* positions of the parties and, therefore, require analysis well in advance of the filing deadline.[32]

Further, Board Rule 25.1 specifies that a provider's PPP must include the following "content": (1) "[f]or each issue, state the material facts that support your claim"; (2) "[i]dentify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting your position"; and (3) "Provide a conclusion applying the material facts to the controlling authorities."[33] Finally, the Board Rules gave the following instruction in Board Rule 25.2 for including exhibits to the preliminary position paper and for identifying unavailable documentation:

> **25.2 – Preliminary Documents**:
>
> **A. General**: With the preliminary position papers, *the parties must exchange all available documentation as preliminary exhibits* to fully support your position. The Intermediary must also give the Provider all evidence the Intermediary considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Intermediary believes is necessary for resolution which has not been submitted by the Provider.
>
> **B. Unavailable and Omitted Preliminary Documents**: *If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available*. Once the documents become available, promptly forward them to the opposing party.
>
> **C. Preliminary Documentation List**: Parties must attach a list of the exhibits exchanged with the preliminary position paper.[34]

The Board notes that its Rules addressing poition papers are authorized by 42 C.F.R. §§ 405.1868(a)-(b) and 405.1853(b). Further, paragraphs (1) and (2) of § 405.1853(b) specify that "the parties must file position papers in order to narrow the issues further" and that "[e]ach

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[32] Board Rule 25 "Commentary" on page 25 (March 1, 2013 & July 1, 2015) (italics and underline emphasis added). *See also* Board Rule 23.3 Commentary (March 1, 2013 & July 1, 2015) ("Because the date for adding issues will have expired and transfers are severly limited, the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opposnent's position.").
[33] *Id.* at 25.
[34] Board Rule 25.2 (Juy 1, 2013 & July 1, 2015) (underline and italics emphasis added).

position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal . . . and the merits of the provider's Medicare payment claims for each remaning issue."

Here, the Provider's RFH issue statements for "Issue 4—SSI percentage" in Case Nos. 14-0761 and 17-0462 is set forth as follows:

> The intermediary erred by incorrectly calculating the SSI percentage for inclusion in the "Medicare Fraction" for purposes of the calculation of the provider's DSH payment.

The Provider describes a very vague, *non-specific* Issue 4—SSI Percentage issue. Even when considering its further description and legal basis, the issue remains vague and overly broad:

> Brief Description of the Issue:
>
> The Provider believes the Intermediary's calculation of the Providers' Medicare DSH payments contains errors in the calculation of the SSI percentage for purposes of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).
>
> Legal Basis for Appeal:
>
> The Provider believes that inclusion of correct data and calculation of the SSI percentage for purposes of the DSH payment is supported by the plain language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).[35]

When considering the specificity of the "contents" requirements in 42 C.F.R. § 405.1835(b), the Board finds the Provider's Issue 4 issue statement to be deficient because the RFH in Case Nos. 14-0761 and 14-0762 failed to meet the "contents" requirements in subsection (b)(2). More specifically, the RFH generically refers to "errors" in the SSI calculation, but fails to include any description of the alleged "errors" (*e.g.*, describe a mechanical implementation error or a statutory interpretation error) much less explain "*why* . . Medicare payment is incorrect for *each* disputed item" or "*how* and *why* Medicare payment must be determined differently for *each* disputed item."[36] Similarly, it fails to comply with Board Rule 8.1: "to *specifically identify* the items in dispute" and describe each item "as narrowly as possible." The Board notes that, by the time the Provider filed its RFHs in 2013, there had been much litigation and several Agency publications describing certain systemic errors in the data matching process used to calculate SSI percentages:

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[35] RFH for Case Nos. 15-1976 & 16-0023 at TAB 3.
[36] (Empahsis added.)

1. *Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. 2006-D20 (Mar. 17, 2006), *rev'd by* CMS Adm'r Dec. (May 11, 2006).

2. *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

3. CMS Ruling 1498-R (April 28, 2010); and

4. 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (adopting a new data matching process post *Baystate* that, among other things, restated CMS' policy that SSI entitlement is based on only 3 specified SSI PSCs).

However, none of these documents nor the detailed alleged errors or issues described therein are referenced in the RFHs. The vague reference to "inclusion of correct data" in the "Legal Basis for the Appeal" section of Isue 4 does noting to cure this deficiency. Similarly, the vague reference in the "Amount in Controversy" section of Issue 4 to certain documents solely in CMS' possession does nothing to cure this deficiency. Specifically, Providers' inability to calculate the amount in controvery because "documents or data relating to CMS's calculation of the adjustment to the DSH payment that were utilized in CMS's calculation of the adjustment . . . are, to the best of the Provider[s'] knowledge, solely in the possession of CMS" does nothing to cure this deficiency. Thus, the Board concludes that the Provider's description of its Issue 4—SSI Percentage issue does not comply with the regulatory specificity requirements (or related Board Rules) mandated for a Board hearing.[37]

In addition, not only is the appeal statement too vague, it clearly does ***not*** refer to the primary issue that is the subject of the EJR, namely issue surrounding the alleged statutory interpretation error relating to what SSI PSCs represent SSI "entitlement" for purposes of the DSH SSI fraction. In particular, there is no discussion or reference to SSI entitlement or SSI status or the SSI-PSC-data-related MMA § 951 data issues.[38] Accordingly, on this basis alone, the Board may dismiss the EJR request for lack of jurisdiction because the SSI Entitlement Issues included in the EJR request were niether properly and timely appealed nor added.

The Board's conclusion is further supported by Provider's own actions in these individual appeals. Even if the Board were to find, *as a threshold matter*, that the Provider's RFH issue statements for Issue 4 comply with the specificity requirements under 42 C.F.R. § 405.1835(b), the Provider's EJR would still fail based on the Board's finding that the Provider's PPPs similarly lacks the requisite detail regarding Issue 4 to consider that issue "fully developed . . . to give the parties a thorough understanding of their opponent's position."[39] The Board observes that, within its PPPs *filed by Plante Moran*, the Provider's Issue 4 description is, as the Provider

[37] *See* 42 C.F.R. §405.1835(b).
[38] The Board notes that the August 16, 2010 final rule adopting the new data matching process discusses in significant detail the SSI status codes that CMS uses to determine SSI entitlement and this final rule is not referenced or discussed in the RFHs. *See* 75 Fed. Reg. at 50280-81.
[39] Board Rule 23.3 Commentary (Mar. 1, 2013 & July 1, 2015) ("because the date for adding issues will have expired and transfers are severely limited, the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position.").

recognizes, "brief" at 7 sentences long and does ***not*** discuss the alleged statutory interpretation error relating to the interpretation of "entitlement to SSI" benefits under the statute, as is emphasized in the issues presented for EJR. Similarly, contrary to the Provider's position, the PPPs *filed by Plante Moran* does not even mention any "data" issues (indeed, the word "data" does not appear in the "brief" 7 sentence-long discussion of Issue 4 in the Providers' PPPs). To this end, the discussion of Issue 4 in the PPPs is bare bones in that it is less than a page (7 sentences long) and includes ***no*** exhibits or footnotes or citations other than oblique references to *Baystate*. Accordingly, even if the RFHs were found to comply with § 405.1835(b) and were found to include the DSH SSI fraction issue relating to SSI entitlement and SSI status codes (and the related MMA § 951 data issue(s)) covered by the EJR request, the Provider's PPPs clearly failed to identify, much less brief, those issues (*i.e*., fully develop its position on that issue "to give the parties a thorough understanding of their opponent's position"). [40] As such, the Board finds that, to the extent Issue 4 in the RFHs could be construed under 42 C.F.R. § 405.1835(b) to properly include the SSI Entitlement Issues (as described in the EJR request), those issues were wholly abandoned in the PPPs.

Indeed, the Board finds that the Provider's briefing of Issue 4 *that did occur* in the PPPs for these cases appear to have been related to the *Baystate* data and match process issue; and this briefing is, in and of itself, wholly inadequate and perfunctory, and fails to comply with the Board Rule 25 requirement to "present fully developed positions." As noted above, the discussion of Issue 4 in the PPPs is a mere 7 sentences long. To that end, the briefing of this issue is limited to generic discussion of alleged but unspecified calculation "errors" that "remain" after the District Court decision in *Baystate* and to the general and vague assertion that the DSH adjustment is "inaccurate and/or incomplete." As such this briefing wholly fails to comply with Board Rules governing position papers. Specifically, the briefing of Issue 4 was not a "fully developed position" and, in particular, did not "state the material facts that support your claim" that there were such "errors" in the SSI fraction. In other words, simply alleging that "errors" remain after the District Court decision in *Baystate* is not a fully developed position that would "give the parties a through understanding of their opponent's position."[41] In addition, to the extent documents were unavailable, Board Rule 25.2 is very clear that the position paper ***must*** describe what documents are unavailable, explain why they are unavailable, describe the efforts made to obtain them, and explain when those documents are expected to become available. However, the PPPs do not contain ***any*** discussion or allegations about unavailable documentation (much less discuss or reference any "data" availability issues[42]). Thus, the Board finds that, while Provider's

[40] If the error is a "statutory interpretation error," then a lack of access to data relates only to the amount in controversy (i.e., defining the scope of the error rather identifying the error).
[41] Board Rule 23.2 Commentary (July 1, 2015) ("Because the date for adding issues will have expired and transfers are severly limited, the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opposnent's position.").
[42] The Board recognizes that, in its RFHs, the Provider suggested that it did not have access to data *to calculate an amount in controversy* but failed to describe what data it needed or was unavailable. To any extent it was or otherwise could be considered a distinct and separate issue, the Provider's PPPs abandoned that issue as they are devoid of identifying or discussing ***any*** "data" issues (much less fully developing that issue). If they had addressed the data issue in the PPPs and asserted unavailability, the Board would have expected compliance with Board Rule 25.2.2. Further highlighting the perfunctory nature of the briefing of Issue 4, is the fact that providers *can* obtain

discussion of Issue 4—SSI percentage in the PPPs for the purported *Baystate* data and matching process issues provides some clarification of the Provider's statement of the issue in its RFH, it wholly fails to comply with Board Rules governing the content of PPPs. Moreover, the PPPs clearly abandoned any data availability issues to the extent there was a separate and distinct data availability issue within Issue 4 as stated in the RFHs.

The Board notes that the first place the the Provider raises the SSI Entitlement Issues (*i.e.*, the SSI entitlement and SSI status codes issues and associated SSI-PSC-data-related MMA § 951 data access issues) is in the context of Provider's FPPs. The fact that 5+ years after the filing of its PPPs the Provider changed its representative from Plante Moran to Hall Render does not give the Provider license to ignore the Board's governing regulations and the Board's Rules and to otherwise change, alter, amend, or otherwise transform the Issue 4 that they appealed into something else. Contrary to the Provider's arguments, the Board's governing regulations and its Rules do specify timing and content requirements for presenting the specific issues being appealed and for fully developing its case on each of those issues. Here, it is abundantly clear that the Provider failed to timely and properly follow those regulations and Rules in these two cases with respect to the presentation and development of the SSI Entitlement Issues as described in the FPPs and EJR reqeust. In particular, as provided by 42 C.F.R. § 405.1835(e), there is only a limited 60-day window in which to add issues to an appeal and that window had closed roughly 7 years prior to the Provider's filing of its FPPs in March 2021.[43]

Finally, the Board addresses the other remaining issue in this case, Issue 2 (concerning the omission of exhausted dual eligible days from the DSH Medicaid fraction) and agrees with the Medicare Contractor that the Provider wholly abandoned Issue 2. While the Provider did brief Issue 2 in its PPPs for these two cases (as filed by Plante Moran), the Provider failed to brief Issue 2 in its FPPs for these two cases (as filed by Hall Render). Rather, the Provider only presented one issue in its FPP and this was clearly only Issue 4. As noted above, the only issue identified in the FPPs was a verbatim quote of Issue 4 from the RFHs. Similarly, the ensuing argument section of the FPPs is devoted only to the development of the improperly-added SSI Entitlement Issues. Accordingly, as the Provider failed to comply with Board Rule 25 requiring each remaining issue to be briefed, the Board considers Issue 2 wholly abandonned in these two cases and necessarily finds that it is no longer part of these two cases.

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certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS"). *See e.g.*, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh (last accessed Mar. 19, 2021); https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH (last accessed Mar. 19, 2021) (CMS webpage describing access to DSH data ***from 1998 to 2017***: "DSH is now a self-service application. This new self-service process enables you to enter your data request(s) and retrieve your data files through the CMS Portal."). Finally, while the Board did not review the adequacy of the substance of the EJR request, the fact that certain data related to the calcluaiton of SSI ratios is available *may* raise concerns about whether factual development potentially may be needed for the EJR request.

[43] The NPRs appealed were dated May 20, 2013 for FY 2009 and August 2, 2013. As a result, the deadline to file an appeal (*i.e.*, 185 days from the date of the NPR per 42 C.F.R. § 405.1835(a)(3)) was Thursday November 21, 2013 for FY 2009 and Monday, February 3, 2014 for FY 2010; and the deadline to add issues (*i.e.*, 245 days from the date of the NPR per 42 C.F.R. § 405.1835(e)(3) which was relocated from § 405.1835(c)(3)) was Monday, January 20, 2014 for FY 2009 and Friday, April 4, 2014 for FY 2010.

Conclusion:

1) The Board hereby **denies** the EJR request of Hillsdale Community Health Center (Prov. No. 23-0037) in Case Nos.14-0761 and 14-0762 because the issues presented for EJR therein were not included in *either* Providers's RFHs *or* preliminary position papers. As a result, the Board lacks the requisite jurisdiction under 42 C.F.R. § 405.1842(f)(2).

2) The Board hereby **dismisses** the Issue 4—SSI Percentage issue in its entirety from Case Nos. 14-0761 and 14-0762 as the issue statement in the RFHs for these cases does not comply with the specificity requirements under 42 C.F.R. § 405.1835(b)[44] and Board Rule 8[45] and, even if it had, the Provider effectively abandoned that issue in its entirety by filing perfunctory preliminary position papers that failed to comply with Board Rule 25 requirements governing preliminary position papers and accompanying exhibits.[46]

3) The Board hereby **dismisses** Issue 2: Medicaid Fraction-Exhausted days because it finds that this issue was not briefed in the Provider's final position paper. In fact, the final position paper only briefs Issue 4. Consequently, the Provider abandoned Issue 2 and it is no longer part of the case.

4) The Board hereby **dismisses** Case Nos. 14-0761 and 14-0762 as there are no other issues pending in these cases.

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 Member Participating

Clayton J. Nix, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

6/4/2021

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS
Wilson Leong, FSS

[44] Pursuant to the Board's authority under the same regulation.
[45] Pursuant to the Board's authority under 42 C.F.R. § 405.1868.
[46] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Jurisdictional Determination***
Enloe Medical Center (Prov. No. 05-0039)
FYE 06/30/2016
Case No. 20-1753

Dear Ms. Ellis and Ms. Frewert,

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

Background

On April 23, 2019, the Provider filed its Request for Reopening in which the Provider requested a recalculation of the Medicare SSI percentage based upon the Provider's cost report period in accordance with 42 C.F.R. § 412.106(b)(3). On June 4, 2019, the MAC issued the Notice of Reopening advising that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio." On December 23, 2019, the MAC issued the Notice of Amount of Corrected Reimbursement (RNPR).[1]

On June 4, 2020, Toyon Associates, Inc. ("Toyon") filed the individual appeal for the Provider and the Board assigned the appeal to Case No. 20-1753. The appeal includes the following two issues:

1. **Medicare Disproportionate Share Hospital ('DSH") Payments – Accuracy of CMS Developed SSI Ratio.** The Provider disputed the SSI Ratio generated by CMS and used by the Medicare Contractor in calculating the Medicare DSH payment. The Provider found that "[t]he SSI ratio is understated due to flaws and inaccuracies in CMS's match process of Medicare patient records with Social Security Administration records."[2]

[1] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[2] Request for Hearing at 1 (June 4, 2020).

2. **Medicare DSH Payments – Inclusion of Medicare Part C Days in the SSI Ratio.** The Provider contends that "CMS' new interpretation of including Medicare Part C Days in the SSI ratio issued is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the *Northeast Hospital* decision."[3]

The Provider referenced Audit Adjustment No. 4 for both issues. Audit Adjustment No. 4 was issued "[t]o adjust SSI Percentage and Disproportionate Share Amount on the latest CMS letter of SSI Percentage Realignment."

Board Determination

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

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

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

[3] *Id.*

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

The Board finds that it does not have jurisdiction over the two issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request, and did not specifically adjust the Accuracy of CMS Developed SSI Ratio issue, nor the DSH Inclusion of Medicare Part C Days in the SSI Ratio issue. As a result, the Provider does not have the right to appeal these issues under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The adjustment and reopening in this case were issued as a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. Based on the Reopening Request and Adjustment #4, the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. The Board has consistently found that it does not have jurisdiction over the Accuracy of CMS Developed SSI Ratio issue, nor the DSH Inclusion of Medicare Part C Days in the SSI Ratio issue when these issues are appealed from a revised NPR issued as a result of a provider's request for realignment of its SSI percentage. As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

> (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 (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -

[4] 42 C.F.R. § 405.1889(b)(1).

> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[5]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[6] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[7]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year. . . .*

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal*

[5] (Emphasis added.)
[6] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[7] (Emphasis added.)

> *fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[8]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days or Part A days) because that data had been previously gathered on a month-by-month basis and there is no need for CMS to rerun the data matching process in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

In other words, the relevant RNPR was only being reopened to include the realigned SSI percentage. Since the only matter specifically revised in the RNPR was to realign the SSI percentage from federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the two issues in the subject individual appeal. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[9]

In conclusion, the Board ***dismisses*** the Accuracy of CMS Developed SSI Ratio and the DSH Managed Care Part C days issues appealed from the RNPR in Case No. 20-1753 as the Provider does not have the right to appeal the RNPR at issue for this issue. Consequently, the Board denies the transfer of these two issues to the respective group appeal Cases Nos. 19-2381G and 19-2380G. As there are no other issues in the individual appeal, the Board hereby closes Case No. 20-1753 and removes it from the Board's docket.

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

Board Members Participating:
Clayton J. Nix, Esq.
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Robert A. Evarts, Esq.
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Kevin D. Smith, CPA

FOR THE BOARD:

6/10/2021

X Clayton J. Nix

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination***

15-1462GC	Advocate Health Care 2012 DSH SSI Ratio Dual Eligible Days CIRP
16-0039GC	Cook County Chicago 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
16-2403GC	Palmetto Health 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
17-0366GC	Mayo Clinic Health System 2013 DSH SSI Fraction Dual Eligible Days CIRP Grp.
17-0532GC	Advocate Health Care 2013 DSH SSI Ratio Dual Eligible Days CIRP Group
17-2009GC	Community Health Network 2014 DSH Medicare Fraction Dual Eligible Days CIRP
18-0236GC	Medisys Health Network 2014 DSH SSI Dual Eligible Days CIRP Group
18-1423GC	Medisys Health Network 2015 -2016 DSH SSI Dual Eligible Days CIRP Group
18-1489GC	Community Health Network 2015 DSH Medicare Fraction Dual Eligible Days CIRP
19-1246GC	Community Health Network CY 2016 DSH SSI Fraction Dual Eligible Days CIRP
20-1472GC	Community Healthcare System (IN) CY 2017
20-1473GC	McLaren Health CY 2016 DSH SSI Ratio Dual Eligible Days CIRP Group
20-1984	John H. Stroger Jr. Hospital of Cook County (Prov. No. 14-0124, FYE 11/30/09)

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above Providers' request for expedited judicial review ("EJR Request") received May 17, 2021 regarding the above-referenced cases consisting of one individual appeal and twelve (12) common issue related party ("CIRP") groups. The Board's determination regarding the EJR request is set forth below.

Issue for which EJR is Requested:

The Providers, in the above-referenced individual appeal and 12 CIRP group appeals are requesting EJR for the following issue:

> The days at issue in these appeals are days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in these appeals is whether the Intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction" for purposes of calculating the Provider's [Disproportionate Share Hospital ("DSH")] payment, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."

> [The] Providers respectfully assert that under the rules of statutory construction [CMS] is *compelled to interpret "entitlement to SSI" benefits to include all inpatients who were eligible for and/or enrolled in the SSI program at the time of their hospitalization* ***and***, further, to *furnish Providers with a listing of those SSI Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare Act*. Furthermore, [t]he Providers seek a ruling that CMS has failed to provide the them with adequate information to allow them to check and challenge CMS'[] disproportionate patient percentage ("DPP") calculations. The Providers are entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173. . . . Because the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of the hospital's Medicare patients who are enrolled in SSI and/or eligible for SSI benefits along with their corresponding SSI status codes, and does not give the Providers any meaningful means of challenging the SSI days chosen by CMS to be used in Provider's DPP calculations, CMS continually violates its § 951 mandate.[1]

Medicare Disproportionate Share Hospital (DSH) Payment Background:

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[2] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[3] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[4] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

[1] EJR Request at 2-3 (emphasis added).
[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[4] (Emphasis added.)

> (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 (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[5]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[6] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[7] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[8]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[9]

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[5] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[6] 42 U.S.C. § 1382.
[7] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[8] 20 C.F.R. § 416.202.
[9] 42 U.S.C. § 426.

In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[10]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[11] and may terminate,[12] suspend[13] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[14] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[15]
2. The individual fails to apply for other benefits to which the individual may be entitled;[16]
3. The individual fails to participate in drug or alcohol addiction treatment;[17]
4. The individuals is absent from the United States for more than 30 days;[18] or
5. The individual becomes a resident of a public institutions or prison.[19]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[20]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[21] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[22] To compute the Medicare fraction, CMS had to match

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[10] 42 U.S.C. § 426-1.
[11] 20 C.F.R. § 416.204.
[12] 20 C.F.R. §§ 416.1331-1335.
[13] 20 C.F.R. §§ 416.1320-1330.
[14] 20 C.F.R. § 1320.
[15] 20 C.F.R. § 416.207.
[16] 20 C.F.R. § 416.210.
[17] 20 C.F.R. § 416.214.
[18] 20 C.F.R. § 416.215.
[19] 20 C.F.R. § 416.211.
[20] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[21] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[22] *Id.*

individual Medicare billing records to individual SSI records.[23] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[24] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[25]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[26]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[27] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the

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[23] *Id.*
[24] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[25] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[26] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.
[27] CMS-1498-R at 5.

forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[28] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[29]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[30] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[31]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[32] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[33] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[34] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[35] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[36]

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[28] *Id.*
[29] *Id.* at 5-6.
[30] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[31] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[32] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[33] *Id.* at 50280.
[34] *Id.* at 50280-50281.
[35] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[36] *Id.* at 50285.

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[37] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[38] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[39]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[40]

As a result of the Rulings, new regulation, and new data match process, CMS calculated SSI percentages for the Providers for all of fiscal years at issue in the individual and CIRP group appeals.[41] The Providers have appealed the SSI percentages based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

Providers' Request for EJR:

The Providers assert that, under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration ("SSA") for the month in question. The Providers contend that

[37] CMS-1498-R at 6-7, 31.
[38] *Id.* at 28, 31.
[39] 75 Fed. Reg. at 24006.
[40] CMS-1498-R2 at 2, 6.
[41] For example, CMS published the SSI ratios for FY 2012 on or about June 12, 2014. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[42]

The Providers note that, in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the FY 2011 IPPS Final Rule that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[43] Thus, the Providers allege the exclusion of the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the DSH statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' disproportionate patient percentage ("DPP") calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA").[44]

Decision of the Board:

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

A. Board Review of Compliance with the Reimbursement Requirement of an Appropriate Cost Report Claim Pursuant to 42 C.F.R. § 405.1873

The following Providers appealed from final determinations and/or the untimely issuance of a final determination covering cost reporting periods beginning on or after January 1, 2016, and are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim:[45]

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[42] 75 Fed. Reg. at 50275-86.
[43] *Id.* at 50281.
[44] Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).
[45] 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").

- Case No. 18-1423GC – #3 Jamaica Hospital Medical Center (Prov. No. 33-0014; FYE 12/31/2016);
- Case No. 19-1246GC – All 5 participating providers;
- Case No. 20-1472GC – All 3 participating providers;

Effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[46]

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"[47] 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.[48] As no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[49] 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.[50] 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).

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[46] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[47] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[48] *See* 42 C.F.R. § 405.1873(a).
[49] 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."
[50] Although no question was raised in this appeal regarding whether an appropriate claim was made, there is evidence in the record supporting that these Providers protested the group issue on the relevant cost reports affected by these regulations as evidenced by Tab D of the jurisdictional documents for each Provider which accompanied the Schedules of Providers.

B. Jurisdiction

*1. Jurisdiction of Providers appealing NPRs Beginning **Prior to** January 1, 2016*

a. *Dismissal of LIP Issue from Case Nos. 15-1462GC and 16-0039GC as there are no IRF/LIP providers in these cases*

The statement of the issue that accompanied the original hearing request in Case No. 15-1462GC and 16-0039GC raised a question concerning both DSH as it relates to IPPS providers ("IPPS/DSH providers") and LIP as it relates to IRF providers ("IRF/LIP providers"). However, the Schedule of Providers for these two cases does not list any IRF/LIP providers or subproviders. Therefore, the Board must conclude that there are no IRF/LIP providers and that the LIP issue is consequently moot. As such, the Board dismisses the LIP issue.

To the extent, there had been any IRF/LIP providers or subproviders in Case Nos. 15-1462GC and 16-0039GC, the Board would still dismiss the LIP issue because 42 U.S.C. § 1395ww(j)(8)(B) precludes administrative or judicial review of LIP issue. Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the U.S. Court of Appeals for the District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar* ("*Mercy*")[51] confirms that the LIP issue is precluded. The D.C. Circuit in *Mercy* affirmed the District Court's decision[52] which concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The D.C. Circuit concluded that the statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[53] Since jurisdiction over an issue is a prerequisite to grant a request for EJR, the Board would deny the EJR request as it relates to any LIP/IRF providers included in the request for EJR for the LIP issue under Case Nos. 15-1462GC and 16-0039GC.

b. *Dismissal of Two Participants in Case No. 17-2009GC Appealing from RNPRs:*
 # 4 Community Hospital South (Prov. No. 15-0218; FYE 12/31/2014)
 # 6 Community Hospital North (Prov. No. 15-0169; FYE 12/31/2014)

Participant # 4 and # 6 in Case No. 17-2009GC each appealed the SSI Eligibility issue from a revised notice of program reimbursement ("RNPR"). The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2017), which provides in relevant part:

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[51] 891 F.3d 1062 (June 8, 2018).
[52] *Mercy Hosp., Inc. v. Burwell,* 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[53] *Mercy*, 891 F.3d at 1068.

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

Additionally, 42 C.F.R. § 405.1889 (2017) explains the effect of a cost report revision:

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

The Board finds that it does not have jurisdiction over the SSI Eligibility issue for Participant ##4 and 6 in Case No. 17-2009GC because, pursuant to 42 C.F.R. § 405.1889(b) (as referenced in § 405.1835(a)(1)), neither participant had a right to appeal this issue from the RNPRs at issue.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[54] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. The audit adjustments associated with the RNPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year and did not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision to the monthly data since the underlying monthly data remains the same).[55] Since the only matters specifically revised in the

[54] 42 C.F.R. § 405.1889(b)(1).

[55] CMS does not re-run the data match process when it processes an SSI realignment request and issues a realigned SSI percentage. CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). All of the underlying data which is

RNPRs for Participant ## 4 and 6 in Case No. 17-2009GC was to realign the SSI percentage from federal fiscal year to the provider fiscal year, the Board does not have jurisdiction over the RNRP appeals of these two participants. Notwithstanding, the Board notes that the same Providers also appealed their original NPR for the same fiscal year and remain in the group as Participant ##3 and 5 in Case No. 17-2009GC

*c. Remaining Participants with Cost Reporting Periods Beginning **Prior to** January 1, 2016*

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[56] 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.[57]

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

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

[56] 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.).

[57] *Bethesda*, 108 S. Ct. at 1258-59.

[58] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

("*Banner*").[59] 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.[60]

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

Based on its review of the record, the Board finds that each of the remaining participants in the 12 CIRP groups and the individual appeal who filed from NPRs beginning ***prior to*** January 1, 2016 filed timely and proper appeals. In this regard, the Board finds that the above Providers are governed by CMS Ruling CMS-1727-R and that the above Providers' appeal are permitted under the dictates of CMS-1727-R because they self-disallowed their claims based on the uncodified regulation at issue (as discussed *infra*) and are challenging the validity of that regulation.

2. *Jurisdiction of Providers appealing Cost Reporting Periods Beginning **On or After** January 1, 2016*

The remaining Providers are appealing from cost reporting periods beginning ***on or after*** January 1, 2016 based on an NPR. The Board notes that the November 13, 2015 OPPS Final Rule eliminated the jurisdictional requirement of *an appropriate cost report claim* in existing §§ 405.1835(a)(1) and 405.1840(b)(3) for Board appeals of cost reporting periods beginning on or after January 1, 2016.[61] Based on its review of the record, the Board finds that each of these Providers filed timely and proper appeals.

3. *Jurisdiction over the groups*

The participants' documentation in all of the EJR requests shows that the estimated amount in controversy exceeds $50,000 in each group, as required for a group appeal.[62] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying

[59] 201 F. Supp. 3d 131 (D.D.C. 2016).
[60] *Id.* at 142.
[61] 80 Fed. Reg. 70298 (Nov. 13, 2015).
[62] *See* 42 C.F.R. § 405.1837.

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

C. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a *revised* data match.[63] The Secretary also stated in the Ruling that, where cost reports had not been settled, those providers SSI fraction would be calculated using the *revised* data match process to be published through rulemaking.[64]

Contemporaneous with CMS Ruling 1498-R[65] the Secretary published a proposed IPPS rule[66] which proposed to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the 2011 Final IPPS Rule in which the Secretary explained that:

> . . . we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[67]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the

[63] CMS Ruling 1498-R at 27.
[64] *Id.* at 31.
[65] *Id.* at 5.
[66] 75 Fed. Reg. 23852, 24002-07.
[67] 75 Fed. Reg. at 50277.

> MedPAR file that we are not able to locate in the EDB[68]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[69]

The Secretary did not incorporate the above new policy involving the revised data match process into the Code of Federal Regulations. However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a binding data match process to be used by the Medicare Contractors in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2).

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but *uncodified* regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[70] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility.[71] As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in the individual and CIRP group appeals.

Finally, to the extent the Providers are attempting to raise a separate subissue for EJR relating to MMA § 951, the Providers have failed to explain with sufficient detail what regulation (codified or uncodified) or statutory provision is being challenged. The Providers' make the broad

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[68] (Medicare) Enrollment Database.
[69] 75 Fed. Reg. at 50285.
[70] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[71] Section III.B of the Providers' EJR request at 15-16 of the EJR Request makes clear that the Providers are challenging CMS' policy of only using 3 SSI PSC codes for determining SSI entitlement and, as such, are challenging the vailidity of the Uncodified SSI Data Match Regulation to which they referenced in the EJR request and recognized the Board is otherwise bound to apply.

allegations that: (1) CMS violates its MMA § 951 mandate "[b]ecause the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of the hospital's Medicare patients who are enrolled in SSI and/or eligible for SSI benefits along with their corresponding SSI status codes, and does not give the Providers any meaningful means of challenging the SSI days chosen by CMS to be used in the Providers' DPP calculations"[72] and (2) "the PRRB may not order CMS or the MAC to furnish the Providers with all SSI days data applicable to its fiscal period under appeal here—leaving the Providers in the impossible position of being unable to prove their claims given that CMS keeps the supporting data hidden."[73] However, the Providers' EJR request fails to identify the relevant regulations (codified or uncodified) underlying these allegations or explain how MMA § 951 otherwise binds the Board relative to these allegations.[74]

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It does not have jurisdiction over Participant ## 4 and 6 in Case No. 17-2009GC.

2) It has jurisdiction over the matter for the subject years and that the remaining participants in the individual appeal and the 12 CIRP group appeals are entitled to a hearing before the Board;

3) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule 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 authority to decide the legal question of whether the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation (as adopted in the preamble to the 2011 Final IPPS Rule) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to

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[72] EJR Request at 2-3.
[73] EJR Request at 15-16. It is unclear what the phrase "the PRRB may not order CMS or the MAC" is means (*e.g.*, the Board may issue but not enforce a favorable decision versus the Board lacks of authority to issue a favaroable decision).
[74] MMA § 951 simply requires "the Secretary to arrange to furnish" to hospitals certain data related to computing the DSH adjustment calculation. However, this provision is referenced only twice in the EJR request and there is no explanation of how the Secretary implemented it. For example, the Board is aware that the Secretary implemented MMA § 951 as part of the FY 2006 IPPS Final Rule. 70 Fed. Reg. 47278, 47438-43 (Aug. 12, 2005). However, none of the potentially relevant portions of this final rule are referenced.

institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

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 appeals.

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA

For the Board:

6/16/2021

X Clayton J. Nix

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

cc: Danene Hartley, NGS
Byron Lamprecht, WPS
Pam VanArsdale, NGC
Laurie Polson, Palmetto GBA c/o NGS
Wilson Leong

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Determination***
Texas Health Presbyterian Hospital Dallas, (45-0462) FYE 12/31/2007 *as a participant in*

THR 2007 SSI Fraction Medicare Managed Care Part C Days CIRP
Case No. 16-1939GC; ***and***

THR 2007 Medicaid Fraction Medicare Managed Care Part C Days CIRP Group
Case No. 16-1940GC

Dear Ms. Goron and Mr. Tisdale:

The Provider Reimbursement Review Board ("Board") has reviewed the above referenced Medicare Managed Care Part C Days common issue related party ("CIRP") groups. The issue in these groups is governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R. Under the terms of this Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020). However, prior to issuing a remand for the groups, the Board finds a jurisdictional impediment with regard to the sole participant in both groups, Texas Health Presbyterian Hospital Dallas (45-0462). The background of the cases and the Board's determination are set forth below.

Background:

On June 28, 2016, Healthcare Reimbursement Services, Inc. ("HRS") filed the group appeals. Both groups were formed with a *single* Provider, Texas Health Presbyterian Hospital Dallas (45-0462), which appealed from a Revised Notice of Program Reimbursement ("RNPR") dated December 31, 2015.

HRS failed to provide copies of the Provider's Request to Reopen and the Notice of Reopening of the Cost Report for the Provider in compliance with Board Rules 7.1.2.1 and 21.2.2. The RNPR

audit adjustment referenced was Audit Adjustment No. #5 which was issued "to update the allowable DSH percentage based on the additional Medicaid and [*sic*] Labor & Delivery Days."[1]

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2016), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

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

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

42 C.F.R. § 405.1835(a) explains a provider's right to appeal to the Board and specifically references § 405.1889(b):

> (a) *Right to hearing on final contractor determination*. A provider (but no other individual, entity, or party) has a right to a Board

[1] There was no change to the SSI Percentage on the RNPR audit adjustment report for Texas Health Presbyterian Hospital Dallas.

> hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if—
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under §405.1803. *Exception*: **If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§405.1887(d), **405.1889(b)**, and the ''Exception'' in §405.1873(c)(2)(i)).[2]

As described below, the Board finds that it does not have jurisdiction over Texas Health Presbyterian Hospital Dallas, (Prov. No. 45-0462) as a participant in Case Nos. 16-1939GC and 16-1940GC because the Provider appealed from an RNPR that was issued *solely* to adjust the Medicaid fraction in the DSH calculation and, as a result, did not adjust the SSI fraction, much less SSI Part C Days which is the issue under appeal in these groups.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The Groups has appealed the inclusion of Medicare Part C days in the SSI fraction (also known as the Medicare fraction) of the DSH percentage and the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage.[4] However, as made clear by the RNPR Audit Adjustment Nos. 4 and 5, the reopening for the only participant in these cases was ***solely*** to adjust the Medicaid fraction to add labor and delivery days:

> Audit Adjustment No. 4 "To include additional Medicaid days matched after the initial cost report filing and include Labor & Delivery days not included in [*sic* the] original finalized review"
>
> Audit Adjustment No. 5 "To update the allowable SSI percentage based on the additional Medicaid and [*sic*] Labor & Delivery days"

The reopening did not encompass Part C days and there was no adjustment to either Part C days (which, per 42 C.F.R. § 412.106(b)(2), are included in the SSI fraction of the DSH adjustment calculation) or even the SSI fraction generally. Accordingly, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), the Board finds that Texas Health Presbyterian Hospital Dallas,

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[2] (Bold emphasis added.)
[3] 42 C.F.R. § 405.1889(b)(1).
[4] Per the holdings in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"), Part C days ***must*** be included in either the SSI fraction or Medicaid fraction. Specifically, *Allina* states "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)." 746 F.3d at 1108. As a result, Allina makes clear that the Part C days issue is black or white (i.e., Part C days must either be included in the SSI fraction or the Medicaid fraction) and there should only be one CIRP group for the Part C days issue.

(45-0462), as a participant in Case Nos. 16-1939GC and 16-1940GC, did not have the right to appeal the Part C days issue from the RNPR. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[5]

In conclusion, Texas Health Presbyterian in Case Nos. 16-1939GC and 16-1940GC does not have the right to appeal the RNPR at issue under 42 C.F.R. § 405.1889 for the DSH Part C days issue. As there are no remaining participants in the CIRP groups, the Board hereby closes Case Nos. 16-1939GC and 16-1940GC and removes these cases from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.
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For the Board:

6/17/2021

X Clayton J. Nix

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Michael G. Newell
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RE: ***Jurisdictional Determination***
St. Elizabeth Healthcare FFY 2015 DSH SSI Fraction Part C Days CIRP Group
Case No. 21-1196GC

St. Elizabeth Healthcare FFY 2015 DSH Post 1498R Medicare Part A/SSI% CIRP Group
Case No. 21-1197GC

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Medicare Contractor's ("MAC's") May 13, 2021 correspondence in which it alerted the Board to jurisdictional impediments in the above-referenced appeals. The background of the cases, the pertinent facts and the Board's determination are set forth below.

Background:

On April 13, 2021, Southwest Consulting Associates, Inc. ("SCA/Representative") filed request to establish the following group appeals:

1. Case No. 21-1196GC entitled "St. Elizabeth Healthcare FFY 2015 DSH Post 1498R Medicare Part A/SSI% CIRP Group" (the "SSI percentage case"); and
2. Case No. 21-1197GC entitled "St. Elizabeth Healthcare FFY 2015 DSH SSI Fraction Part C Days CIRP Group" (the "SSI Fraction Part C Days case").

The group issue statement for the SSI percentage case indicates the group is appealing the SSI *Baystate* Errors issue and the issue statement in the SSI Fraction Part C Days case indicates the providers are appealing:

> [T]he exclusion of Medicaid-eligible patient days from the numerator of the disproportionate share hospital ("DSH") Medicaid fraction relating to patients who were enrolled in Medicare Advantage plans under Part C of the Medicare Act with respect to discharges occurring on or after October 1, 2013.

SCA used St. Elizabeth Fort Thomas (Prov. No. 18-0001) as the initial participant to form both groups. In the SSI percentage case, SCA also formed the group with St. Elizabeth Medical Center North (Prov. No. 18-0035). On April 21, 2021 SCA added St. Elizabeth Florence (Prov. No. 18-0045) to the SSI percentage case. All of the Providers were directly added to the groups from Revised Notices of Program Reimbursement ("RNPRs") issued as a result of the provider requests for realignment.[1]

In accordance with Board Rule 15.2, the MAC reviewed the group formations and, in letters dated May 13, 2021, alerted the Board that jurisdictional impediments existed for the referenced providers in the two groups.

The Pertinent Facts for Provider added to both Case Nos. 21-1196GC & 21-1197GC

St. Elizabeth Fort Thomas (18-0001) FYE 12/31/2015
Formed group/Directly Added on April 13, 2021

- Notice of Intent to Reopen dated May 15, 2020
  - The Reopening was issued "To update the SSI% based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 05/05/2020."
- RNPR dated October 21, 2020
- Audit Adjustment 2: was made "[t]o update the SSI % and payment factor in accordance with CMS' SSI realignment calculation."

Pertinent Facts for Additional Providers Added to SSI % Group (Case No. 21-1197GC)

St. Elizabeth Medical Center North (18-0035) 12/31/2015
Formed group/Directly Added to Group on April 13, 2021

- Notice of Intent to Reopen dated May 14, 2020
  - The Reopening was issued "To update the SSI% based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 05/05/2020."
- RNPR dated October 21, 2020
- Audit Adjustment 3: was made "[t]o update the SSI % and payment factor in accordance with CMS' SSI realignment calculation."

St. Elizabeth Florence (18-0045) 12/31/2015
Directly Added to Group on April 21, 2021

- Notice of Intent to Reopen dated May 15, 2020

[1] Neither group is complete yet.

  - The Reopening was issued "To update the SSI% based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 05/05/2020."
- RNPR dated October 28, 2020
- Audit Adjustment 1: was made "[t]o update the SSI % and payment factor in accordance with CMS' SSI realignment calculation."

Board Decision

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

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

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

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

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

42 C.F.R. § 405.1835(a) explains a provider's right to appeal to the Board and specifically references § 405.1889(b):

> (a) *Right to hearing on final contractor determination*. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if—
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under §405.1803. *Exception*: **If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§405.1887(d), **405.1889(b)**, and the ''Exception'' in §405.1873(c)(2)(i)).[2]

As described below, the Board finds that it does not have jurisdiction over the Providers in these groups that appealed from RNPRs because the RNPRs were issued as a result of the Providers' SSI Realignment requests, and did not adjust the SSI percentage and the DSH Part C Days issues, which are the issues under appeal in these groups.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The reopenings in these cases were issued as a result of the Providers' requests to realign their SSI percentages from the Federal Fiscal Year End to their individual cost reporting fiscal year ends. The audit adjustments associated with the RNPRs under appeal clearly revised the SSI percentages in order to realign it from a federal fiscal year to the providers' respective fiscal years. The Notices of Reopening explicitly stated that the purpose of each reopening was issued to use the hospital's fiscal year end to calculate the SSI percentage instead of the federal fiscal year end. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage.

As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

> (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

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

> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[4]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[5] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[6]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year. . . .*

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months*** ***included in the 2 Federal fiscal years***

[4] (Emphasis added.)
[5] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[6] (Emphasis added.)

> ***that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[7]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days or Part A days) because that data had been previously gathered on a month-by-month basis and there is no need for CMS to rerun the data matching process in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

In other words, the determinations were only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPRs were adjustments to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the RNPR appeals of the SSI % and DSH Part C days issues by St. Elizabeth Fort Thomas, St. Elizabeth Medical Center North and St. Elizabeth Florence. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[8]

In conclusion, these participants are dismissed from the CIRP groups as they do not have the right to appeal the RNPRs at issue under 42 C.F.R. § 405.1889 for the Post 1498R Medicare Part A/SSI% and the DSH Part C Days issues. As there are no remaining participants in either CIRP group, the Board hereby closes Case Nos. 21-1196GC and 21-1197GC and removes them from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:
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For the Board:

6/17/2021

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Chair
Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Judith Cummings, CGS Administrators (J-15)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Daniel Hettich, Esq.
King & Spalding, LLP
1700 Pennsylvania Ave NW
Washington, DC 20006

RE: ***Jurisdictional Determination on One Participant***
King & Spalding CY 2006-2008 Part C Days Group
Case No. 19-2693G
Participant: Baptist Hospital (Prov. No. 10-0093; FYE 9/30/2006)

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the King & Spalding CY 2006-2008 Part C Days Group. The issue in this group is governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R. Under the terms of this Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020). However, prior to issuing a remand for the group, the Board finds a jurisdictional impediment with regard to one of the participants, Baptist Hospital (10-0093) for FYE 9/30/2006. The background of the case, the pertinent facts with regard to this participant and the Board's determination are set forth below.

Background:

The King & Spalding CY 2006-2008 Part C Days Group appeal request was filed on September 17, 2019.[1] Two of the Providers in the group appealed from Revised Notices of Program Reimbursement ("RNPR"s):

Provider	**FYE**	**Orig. Case**
Baptist Hospital (10-0093) *ptcp#2*	9/30/2006	13-2853
Union Hospital Association (36-0010) ptcp #6	12/31/2006	13-3476[2]

[1] The group was originally filed for FY 2006 and was subsequently expanded to include CY 2007 in 2019 and CY 2008 in 2020.

[2] Union Hospital Association referenced Audit Adjustment #1 which was issued "[t]o adjust SSI% and LIP% . . . to updated CMS amounts and to update DHS allowable% accordingly." The value specified in the SSI recipient patient days to Medicare Part A patient days changed from 3.11 to 3.39.

Pertinent Facts- Baptist Hospital:

On August 16, 2013, Parker, Hudson, Rainer & Dobbs filed an individual appeal on behalf of Baptist Hospital (Prov. No. 10-0093) for FYE 9/30/2006. The appeal was filed from a RNPR dated February 19, 2013 and the Board assigned the case to Case No. 13-2853. The individual appeal included the Medicare Advantage days issue and referenced Audit Adjustment Nos. 11 and 12.

Baptist Hospital's Medicare Fraction Part C days issue was transferred from Case No. 13-2853 to the subject group case on September 19, 2019.

In its 30 day review letter, dated October 22, 2019, the Medicare Contractor ("MAC") indicated that Baptist Hospital was appealing from a RNPR which did not adjust Part C days.

In response to the MAC's 30 day letter, King & Spalding filed a brief in which it contends that, because the MAC made adjustments that specifically adjusted the SSI fraction and Medicaid days, the statutory and regulatory requirements have been met for this Provider. It asserts that because the MAC adjusted the number of Medicaid days included in the Medicaid fraction, the Provider has a right to appeal all aspects of the calculation.

A. *Baptist Hospital's Requests for Reopening:*

On March 23, 2011, the Provider identified additional Medicaid eligible days which were not included in the original NPR and requested reopening for this issue.

On September 14, 2011, the Provider was dissatisfied with reimbursement since Medicare Bad Debt amounts for the FYE 9/30/2006 listing were inaccurate and requested reopening for this additional issue.

B. Baptist Hospital's Notices of Reopening and RNPRs:

The original NPR was issued on September 15, 2008.[3]

On April 14, 2011, the MAC advised that the cost report was being reopened "[t]o revise the Medicare-SSI fraction in the DHS calculation to ensure the accurate inclusion of Medicare Advantage data submitted by providers, which will be included in revised SSI ratios to be published by CMS."[4]

On November 18, 2011, the MAC advised that the cost report was also *reopened* "[t[o include Inpatient and Outpatient Medicare Bad Debts."[5]

On November 20, 2012, the MAC issued a revised NPR addressing the April 14, 2011 reopening.[6]

---

[3] As confirmed by the April 14, 2011 notice of reopening issued by the MAC. *See also infra* note 6.
[4] This corresponds with the RNPR issued on November 20, 2012 as reflected in Audit Adjustment Nos. 4 and 5.
[5] This corresponds with the RNPR issued on February 19, 2013 as reflected in Audit Adjustment Nos. 3-6 associated with "Reopening B." To this end the Provider marked "Reopening B" on the November 18, 2011 notice of reopening.
[6] While the November 20, 2012 determination is listed as an NPR as opposed to an RNPR, the documentation in the record establishes that it is an RNPR. The summary page for the Audit Adjustment Report refers to the "previous"

On February 12, 2013, the MAC advised that the cost report was also *reopened* "[t[o revise the Medicare DSH calculation to include additional Medicaid eligible days." The copy of this reopening included in the record has "Reopening C" handwritten on it.

On February 19, 2013, the MAC issued the RNPR at issue. The Provider's appeal refers to Audit Adjustment Nos. 11 and 12 from the RNPR at issue. Audit Adjustment No. 11 was made to adjust the allowable DSH percentage and Audit Adjustment No. 12 was made to adjust Medicaid Days (both adjustments refer to "Reopening C").[7]

Board Decision

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

A. Relevant Regulations – Revised NPRs

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

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

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

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

NPR, what is being "corrected in the RNPR and the summary "adjustment." Further, the first page of the cost report prepared "11/12/2012" notes in the field marked for "Intermediary Use Only" has an "x" in the box to denote "reopened" cost report. Finally, the April 14, 2011 notice of reopening states that the "date of previous notice of program reimbursement" was September 15, 2008 and, as a result, the November 20, 2012 determination had to be an RNPR.

[7] Reopening C corresponds with the (3rd) Eligible Days Reopening issued on February 12, 2013 and the RNPR under appeal dated February 19, 2013.

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

Accordingly, pursuant to 42 C.F.R. § 405.1889(b) (and § 405.1835(a)(1) which references that regulation), the Board has jurisdiction only over those matters that have been "specifically revised" in a revised determination. More specifically, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[8]

Here, the Board finds that it does not have jurisdiction over Baptist Hospital (FYE 9/30/2006) as a participant in this group. The Provider appealed from an RNPR that did not change the SSI percentage – the RNPR dated February 19, 2013. The Audit Adjustments referenced in the Provider's appeal request are Audit Adjustment Nos. 11 and 12 and they refer ***solely*** to the Eligible Days Reopening issued on February 12, 2013. Specifically, Audit Adjustment No. 11 was made "[t]o adjust the Allowable DSH Percentage (E pt. A in 5.03) (Reopening C)"; and Audit Adjustment 12 was made "[t]o adjust Medicaid Days for DSH Purposes (Reopening C)." As hand notated by the Provider on the February 12, 2013 Reopening, this reopening was "Reopening C" and was solely "[t]o revise the Medicare DSH calculation to include additional Medicaid eligible days."

The only manner in which the Board has determined that it has jurisdiction over the Part C days issue *in the context of a RNPR* is if: (1) the SSI percentage is specifically adjusted for Part C Days; ***or*** (2) the data match process is rerun to generate a new and different SSI percentage where the Board must necessarily assume that there was a change in the underlying data changed and that the Part C days also changes.[9] Here, the SSI percentage clearly was not adjusted for Part C days and, unless there is evidence to the contrary (which there is not), the Board must presume the underlying Part C days data was not changed for Baptist Hospital since there was no change in or adjustment to the SSI percentage itself. In this regard, the Board notes that the Provider is challenging the regulation promulgated in the August 11, 2004 final rule that requires these Part

---

[8] 42 C.F.R. § 405.1889(b)(1).

[9] This second situation does ***not*** encompass a realignment of the SSI percentage because CMS does ***not*** rerun the data match process in order to effectuate a realignment but rather uses pre-existing data previously gathered on a month-by-month basis to effectuate the realignment. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis); 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period."); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

C days to be counted in the SSI fraction and there is no dispute about the amount or number of Part C days included in the SSI fraction itself. Accordingly, if Baptist Hospital wished to appeal or contest the Part C days issue for FY 2006, it should have appealed that issue from its original NPR when it clearly had the right to do so since appeals of any potential future RNPRs is limited to matters "specifically revised."[10]

In summary, because there was no revision to the SSI percentage in the February 19, 2013 RNPR that Baptist Hospital appealed for FY 2006, the audit adjustments associated with that RNPR do not meet the requirements of the regulation for Board jurisdiction of matters revised in a revised NPR and the Baptist Hospital does not have a right to appeal that RNPR for FY 2006 under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[11] Therefore, the Board dismisses Participant No. 2, Baptist Hospital for FY 2006, from the group pursuant to 42 C.F.R. § 405.1889. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of this appeal.

The Board will issue a determination regarding the applicability of CMS-1739-R for the remaining participants in the group, Case No. 19-2693G, under separate cover.

Board Members:
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Robert A. Evarts, Esq.
Susan A. Turner, Esq.
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For the Board:

6/21/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc. (J-N)

[10] For context, the Board takes administrative notice that:

1. The final rule establishing the Agency's current policy on treatment of Part C days in the SSI fraction (and the one at issue in this case) was issued on August 11, 2004 and the Agency's Part C days policy, both prior to and following the August 11, 2004 final rule, has been subject to much litigation. *See, e.g.*, *Northeast Hosp. Corp. v. Sebelius*, 699. Supp. 2d 81 (D.D.C. 2010), *aff'd by*, 657 F.3d 1 (D.C. Cir. 2011); *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012), *aff'd by*, 746 F.3d 1102 (D.C. Cir. 2014); *King & Spalding Inclusion of Medicare Advantage Days in 2007 SSI Ratios v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D38 (June 29, 2010) (This "D-" decision is an EJR determination. The Board does not routinely publish EJR determinations as "D-" decisions and will do so only when the EJR determination is *seminal*.).
2. Most providers filing Board appeals of the Part C days issue have done so by appealing from their original NPR, regardless of whether that NPR was issued prior to or after 1498-R (including certain appeals filed pre- 2010 in which the provider later requested bifurcation of the Part C days issue from dual eligible days issues emanating from the same August 11, 2004 final rule).

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Decision***
Doctors Hospital at Renaissance (Prov. No. 45-0869)
FYE 12/31/2015
Case No. 19-2792

Dear Ms. Griffin,

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

Pertinent Facts:

The Provider filed its appeal request on September 30, 2019, appealing from its Notice of Program Reimbursement ("NPR") dated April 3, 2019. The Provider claims its Uncompensated Care Calculation ("UCC") Disproportionate Share Hospital ("DSH") payment was understated for several reasons. First, it claims that the process used by the Medicare Contractor ("MAC") when sampling its Uninsured Charity Care charges was flawed, not statistically valid, and improper.[1] It also claims that when determining the allowable uninsured Charity Care charges, the MAC did not follow the mandates of the applicable cost report instructions, resulting in audit adjustments that are arbitrary, capricious, and flawed.[2] In its Preliminary Position Paper, the Provider requests that the Board:

> determine whether the MAC and CMS implemented a procedurally unlawful policy of auditing worksheet S-10 of Provider's [FYE] 12/31/215 cost report that resulted in erroneous disallowances of its [UCC] costs which were improperly used by CMS to calculate the Provider's [FFY] 2020 Uncompensated Care Payments ("UCP") under the Medicare Inpatient Prospective Payment System ("IPPS") Final Rule for FFY 2020.[3]

[1] Request for Hearing at 2 (Sept. 30, 2019).
[2] *Id.* at 2-3.
[3] Provider's Preliminary Position Paper at 1 (May 27, 2020).

The Provider argues that its S-10 was arbitrarily audited without CMS issuing adequate UCC reporting guidelines or going thorough adequate notice and comment requirements.[4] While the Provider acknowledges that the estimates used by the Secretary for the UCC DSH payment is not subject to review, it claims that a procedural challenge regarding the way its Worksheet S-10 audit was conducted (with no prior notice of the standards and process to be utilized in the audit) is permissible.[5]

In its Preliminary Position Paper, the MAC argues that the appealed issue is precluded from administrative and judicial review pursuant to 42 U.S.C. § 1395ww(r)(3). The MAC quotes some of the Board's recent decisions which found it does not have jurisdiction to review UCC payment issues.[6] The MAC insists that the Board does not have the authority to address the majority of the Provider's arguments due to the preclusion of administrative and judicial review, but nevertheless defends its audit of Provider's data as proper.[7]

Relevant Law and Analysis:

A. Bar on Administrative Review

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[8]
>
> (B) Any period selected by the Secretary for such purposes.

B. Interpretation of Bar on Administrative Review

1. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"),[9] the D.C. Circuit Court upheld the D.C. District Court's decision that there

[4] *Id.* at 7-15.
[5] *Id.* at 15.
[6] Medicare Administrative Contractor's Preliminary Position Paper at 5-9 (Sept. 1, 2020).
[7] *Id.* at 9-11.
[8] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[9] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016), *affirming* 89 F. Supp. 3d 121 (D.D.C. 2015).

is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[10] The D.C. Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[11]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[12]

2. DCH Regional Med. Ctr. v. Azar

In *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*"),[13] the D.C. Circuit Court *again* addressed the judicial and administrative bar on review of uncompensated care DSH payments. In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[14] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that the D.C. Circuit had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, it found the same relationship existed with regard to the methodology used to generate the estimates.[15]

[10] 830 F.3d 515, 517.
[11] *Id.* at 519.
[12] *Id.* at 521-22.
[13] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[14] *Id.* at 506.
[15] *Id.* at 507.

3. Scranton Quincy Hosp. Co. v. Azar

In *Scranton Quincy Hosp. Co. v. Azar*,[16] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[17] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[18] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[19] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[20]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[21]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[22] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such

[16] No. 18-32310 (ABJ) (consolidated 19-cv-1602), 2021 WL 65449 (D.D.C. Jan. 7, 2021) ("*Scranton*").
[17] *Id.* at *3.
[18] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[19] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[20] *Id.*
[21] *Id.* at *9.
[22] *Id.* at *10.

review is precluded by statute, the criteria in *Scranton* were not met.[23] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[24]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[25] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

Board Decision:

The Board finds that it does not have jurisdiction over the UCC DSH Payment issue in this appeal. The Provider is arguing that the Secretary departed from its own policies contained in the relevant cost reporting instructions, and that the audit of its S-10 Worksheets was unlawful because the process did not undergo proper notice and comment rulemaking. With regard to any argument that related to the Medicare Contractor's alleged deviation from CMS' stated policy for making the UCC calculation, the D.C. District of Columbia held in *Scranton* that such a challenge is barred from review, succinctly stating that any argument "that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[26]

Likewise, with regard to any attempt to cast the appeal as a challenge to the procedural validity of a policy because the Secretary failed to provide notice of the agency's ultimate data choice, the Board rejects this argument. The relief sought by the Provider is to "reimburse Provider for the Charity Care claims that were disallowed" for its specific hospital based on its specific UCC DSH Payment reflected in its NPR.[27] The D.C. Circuit in *Tampa General* rejected a similar attempt to reframe the challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[28] The same holds true for a similar characterization of a procedural challenge that ultimately challenges the underlying data or methodologies used to generate the estimates for a UCC DSH payment calculation.

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[23] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[24] *Id.* (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[25] *Id.* at *11 (quoting *DCH v. Azar*, 925 F.3d at 509).
[26] *Scranton* at *10.
[27] Provider's Preliminary Position Paper at 21.
[28] 830 F.3d at 521-22.

Based on the above, the Board finds that, pursuant to 42 U.S.C. § 1395ww(r)(3), it does not have jurisdiction over the DSH UCC issue. In denying jurisdiction, the Board notes that the D.C. Circuit's decisions in *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[29] Since the DSH UCC issue is the only remaining issue in this case, the Board hereby closes the case and removes it from its docket.

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

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For the Board:

6/21/2021

X Clayton J. Nix

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination***

19-0374GC	Banner Health CY 2016 Incorrect DGME Cap & Weighting for Residents Beyond IRP Group
21-0081GC	Yale-New Haven CY 2016 Miscalculation of DGME FTE Cap & Resident Weighting Factors Group

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 4, 2021 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.

Issue in Dispute

The issue for which EJR is requested is:

> . . .the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Providers assert that] [t]he regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the statute because it determines the cap after application of weighting factors.[1]

Background

The Medicare statute requires the Secretary[2] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[3] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[4]

[1] Providers' EJR request at 1.
[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395ww(h).
[4] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[5]

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

A hospital's FTE count for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. § 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[6] ("*IRP residents*") are weighted at 100 percent or 1.0, while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "*fellows*") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[7] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

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[5] 42 U.S.C. § 1395(h).
[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three-year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[9] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> • *Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology

[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 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.[12]

To codify this change, the Secretary added clause (iii) to 42 § 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).[13] This regulation is the focus of these appeals and this EJR request, and it states the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

As previously noted, this regulation addresses how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility that year.[15]

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

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[12] *Id.* at 39894 (emphasis added).
[13] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that was in the prior version of the regulation and replacing it them with reference to "the limit described in this section."
[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[16]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, is averaged with the FTE counts from the prior and penultimate years.

The Providers' Position

The Providers assert that the MAC's calculations of the current, prior-year and penultimate-year DGME FTES and the FTE caps are contrary to the statutory provisions at 42 U.S.C. § 1395ww(h), and, as a result, the Providers' DGME payments are understated. The Providers contend that the regulation implementing the cap and the weighting factors is contrary to the statute because it determines the cap after the application of the weighting factors.[17] The effect of this regulation is to impose on the Providers weighting factors that result in reductions greater than 0.5 for many residents who are beyond the IRP, and the regulation prevents the Providers from claiming and receiving reimbursement for their full unweighted FTE caps.[18]

The Providers explain that the Medicare statute caps the number of residents that a hospital can claim at the number it trained in cost years ending in 1996.[19] The statute states that, for residents beyond the IRP, "the weighting factor is .50."[20] The statute also states that the current year FTEs are capped before application of the weighting factors: "the total number of full-time equivalent residents before application of the weighting factors . . . may not exceed the number . . . of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996."[21] The Providers conclude that this statutory scheme sets an absolute weighting factor on fellows of 0.5 and requires that the weighting factors are not applied when capping the current year FTEs.

The Providers claim that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[22] Instead, a weighted FTE cap is determined for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE(UCAP/UFTE) = WCap,[23] is applied to the weighted FTE count in the current year which

[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[18] 42 C.F.R. § 413.79(c)(2).
[19] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[20] *Id.* at § 1395ww(h)(4)(C)(iv).
[21] *Id.* at 1395ww(h)(4)(F)(i).
[22] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[23] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.

creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Providers contend that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[24]

Second, the Providers posit, the weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The Providers explain that the downward impact on the FTE count increases as hospital trains more residents beyond the IRP and the problem increase as a hospital trains more fellows because the methodology amplifies the reduction.

Third, in some situations, as demonstrated by the Table on page 13 of the Providers' EJR request, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Providers point out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.

The Providers conclude that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion. Since, the Board lacks the authority to grant the relief sought, the request for EJR should be granted.

Decision of the Board

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

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

In Case No. 19-0374GC, the Providers appealed from final determinations covering cost reporting periods beginning on or after January 1, 2016, and are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.25 Specifically, effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an

[24] *Id.* at §1395(h)(4)(F)(i).
[25] 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").

appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[26]

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"[27] 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.[28] As no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[29] 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.[30] 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. *Appeals of Cost Report Periods Beginning Prior to January 1, 2016*

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

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[26] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[27] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[28] *See* 42 C.F.R. § 405.1873(a).
[29] 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."
[30] Although no question was raised in this appeal regarding whether an appropriate claim was made, the Board recognizes that the Providers' cost reports affected by these regulations included a claim for the disputed DGME payment as a protested amount in their as-filed cost reports as evidenced by the jurisdictional documents found in the Office of Hearing Computerized Document Management System (OHCDMS) for each Provider. The Providers each included a summary of their Protested amounts which included the DGME calculation and a copy of Worksheet E-4 which demonstrated the Providers claimed a protested amount and/or had an adjustment to protested amounts that reflected a challenge to the DGME cap.
[31] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[32]

On August 21, 2008, new regulations governing the Board were effective.[33] 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*").[34] 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.[35]

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

The Board has determined that the participants in Case No. 21-0081GC involved with the instant EJR request with cost report periods which began prior to January 1, 2016 are governed by CMS Ruling CMS-1727-R. In addition, the participants' jurisdictional documentation show that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[36] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

C. Board's Analysis of the Appealed Issue

[32] *Bethesda*, 108 S. Ct. at 1258-59.
[33] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[34] 201 F. Supp. 3d 131 (D.D.C. 2016).
[35] *Id.* at 142.
[36] *See* 42 C.F.R. § 405.1837.

The Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between residents in their initial training period and fellows. The Providers assert that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this formula results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Providers present the following equation in their request for EJR used to calculate the allowable count for primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [37]

Accordingly, the Board set out to confirm the Providers' assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[38] 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.[39] 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 Providers that § 413.79(c)(2)(iii) essentially states the above equation, albeit in a slightly different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) states:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and

[37] EJR Request at 4.
[38] *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.)).
[39] 66 Fed. Reg. at 39894 (emphasis added).

> 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].[40]

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.[41] 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."[42] 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[43] (*i.e.*, ratios) using variables a, b, c, and d:

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

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[44]

On the other side of the algebraic equation (*i.e.*, the ratio of "c / d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same proportion." This phrase expressed as a ratio ("c/d") is an *unknown* Weighted FTE Cap over the FY's Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting

---

[40] (Emphasis added.)
[41] *See* 62 Fed. Reg. at 46005 (emphasis added).
[42] *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.)).
[43] 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.
[44] 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.

value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

$$\frac{Weighted\ FTE\ Cap\ (c)}{FY's\ Weighted\ FTE\ Count\ (d)} = \frac{Unweighted\ \ FTE\ Cap\ (a)}{FY's\ Unweighted\ FTE\ Count\ (b)}$$

The unknown Weighted FTE Cap (variable "c") is then determined by a/b x d. In other words, the unknown Weighted FTE Cap is determined by the following formula:

$$\boldsymbol{Weighted\ FTE\ cap} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times\ Weighted\ FTE\ Count$$

This formula is clearly stated in the preambles to both the FYs 1998 and 2002 IPPS Final Rules as previously quoted.

Based on the above, the Board finds that 42 C.F.R. § 413.79(c)(2)(iii) does set forth the equation being challenged and, accordingly, that the Providers are challenging the validity of § 413.79(c)(2)(iii). Since 42 C.F.R. § 405.1867 requires that the Board comply with the requirements of the statute and regulations, the Board lacks the authority to eliminate the regulatory provision that creates the alleged penalty in § 413.79(c)(2)(iii) which is the remedy the Providers are seeking. Consequently, EJR is appropriate for the issue under dispute in these cases.

D. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt

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

Board Members Participating:

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

FOR THE BOARD:

6/22/2021

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Danelle Decker, NGS
John Bloom, Noridian Healthcare Solutions
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RE: ***Jurisdictional Determination in Whole***
Toyon Associates CY 2012 Inclusion of Medicare Part C Days in SSI Ratio #3 Group
Case No. 19-1675G

Dear Mr. Chinea and Ms. Frewert:

The Provider Reimbursement Review Board ("Board") has reviewed the January 6, 2020 jurisdictional challenge filed by the Medicare Contractor ("MAC") in the above-referenced appeal. The background of the case, the pertinent facts and the Board's determination are set forth below.

Background:

On April 12, 2019, Toyon Associates, Inc. ("Toyon" or "Representative") filed the subject group appeal. The issue statement indicates the group is appealing "Whether CMS' inclusion of Medicare Part C Days in the SSI Ratio was proper?" Specifically the group is challenging, ". . . the SSI percentage developed by CMS and utilized by the MAC in their updated calculation of the Medicare Inpatient Prospective Payment System's DSH payment. . . . The group maintains the position all Medicare MA or Part C Days should be excluded from the SSI ratio."

On the same day the group was formed, the following two (2) providers transferred to the group from pending individual appeals:

Facts for Participant 1:

Natividad Medical Center (05-0248) 6/30/2012, Case No. 19-0437("Natividad")

- Reopening Request dated September 18, 2017
  - Reopening included the following language:
    The Provider ". . . requests a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year."
- Notice of Reopening dated October 17, 2017
  - The cost report was reopened for the following issue:
    "To adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the fiscal year and to amend the disproportionate share adjustment to account for the change in the SSI ratio."
- Revised NPR dated June 7, 2018.
- Audit Adjustment 4 was made to ". . . revise the SSI Ratio and the allowable DSH% based on the letter for SSI % Realignment."

Facts for Participant 2:

Salinas Valley Memorial Hospital (05-0334) FYE 6/30/2012, Case No. 18-1787 ("Salinas Valley")

- Reopening Request dated July 17, 2017
  - Reopening included the following language:
    The Provider ". . . requests a recalculation of its Hospital SSI ratio for purposesof aligning it with the Hospital's fiscal year ended 6/30/2012."
- Notice of Reopening dated August 16, 2017
  - The cost report was reopened for the following issue:
    "To adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the fiscal year and to amend the disproportionate share adjustment to account for the change in the SSI ratio."
- Revised NPR dated March 12, 2018
- Audit Adjustment 4 was made to "To adjust SSI % to the CMS Recalculated percent based on the provider's fiscal year."

On April 12, 2020, Toyon designated the group complete (fully formed). On November 30, 2020, the MAC challenged the Board's jurisdiction over the two participants appealing from Revised NPRs (Natividad and Salinas Valley).

On December 21, 2020, Toyon submitted a jurisdictional response to the MAC's challenge. In its response, Toyon argues that, when the realignment was done, new days were added to the calculation of the SSI ratio which were not part of the SSI ratios in the original NPRs. Therefore, the Providers contend that the Part C Days should still be removed from the SSI ratio, but the impacted period is 7/1/2011 to 6/30/2012.

In addition, Toyon indicates that Natividad's appeal of the SSI Part C Days issue from its original NPR was pending in Case No. 15-2618G (Toyon 2012 Inclusion of Dual Eligible Part C Days in the SSI Ratio Issued 6/27/13 Group.)[2] Because appeals of the ***same*** issue must be pursued in a single appeal, the Representative does *not* object if the Board wants to consolidate Natividad's RNPR issue from this group with the original NPR issue in Case No. 15-2618G.

Board Decision

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

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

> (a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a) of

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

Additionally, 42 C.F.R. § 405.1889 (2018)[1] explains the effect of a cost report revision:

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

As described below, the Board finds that it does not have jurisdiction over the two Providers in this group that appealed from RNPRs because the RNPRs were issued as a result of the Providers' SSI Realignment requests, and did not adjust the DSH Part C Days issue, which is the issue under appeal in this group.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[2] The reopenings in this case were a result of the Providers' requests to realign their SSI percentages from the Federal Fiscal Year End to their individual cost reporting fiscal year ends. The audit adjustments associated with the RNPRs under appeal clearly revised the SSI percentages in order to realign it from a federal fiscal year to the providers' respective fiscal years. The Board has consistently found that it does not have jurisdiction over the DSH Managed Care Part C Days issue when it is appealed from a revised NPR issued as a result of a provider's request for realignment of its SSI percentage.

As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

> (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

[1] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[2] 42 C.F.R. § 405.1889(b)(1).

> (B) Are furnished to patients who **during that month** were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[3]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[4] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived *from the data match process* ***for the two Federal fiscal years that spanned the hospital's cost reporting period***."[5]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*. . . .

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify*

[3] (Emphasis added.)
[4] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[5] (Emphasis added.)

> *its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[6]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days) because that data had been *previously* gathered on a month-by-month basis and there is no need for CMS to rerun the data matching process in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

In other words, the determinations were only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPRs were adjustments related to realigned SSI percentages, the Board does not have jurisdiction over Natividad and Salinas Valley. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[7]

Finally, with regard to the MAC's challenge of the duplication of Natividad's appeal of the SSI Part C Days issue from its original NPR 2012 in Case No. 15-2618G, the Board granted expedited judicial review in that group on October 18, 2018, which resulted in closure of the case. Accordingly, Natividad's pursuit of the Part C days issue in this optional group is a prohibited duplicate appeal and serves as an alternative basis for dismissing Natividad. It is unclear whether Salinas Valley Memorial Hospital similarly pursued the Part C days issue from its original NPR whether as part of a group or individual appeal.

In conclusion, these two participants are dismissed from the CIRP group as they do not have the right to appeal the RNPRs at issue under 42 C.F.R. § 405.1889 for the DSH Part C days issue. As there are no remaining participants in the group, the Board hereby closes Case No. 19-1675G and removes it from the docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

For the Board:

6/22/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Judith Cummings, CGS Administrators (J-15)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Determination***
QRS CY 2006 DSH SSI Fraction Medicare Managed Care Part C Days (4) Group
Case No. 20-0247G

QRS CY 2006 DSH Medicaid Fraction Medicare Managed Care Part C Days (4) Group
Case No. 20-0249G

Dear Mr. Ravindran and Ms. VanArsdale:

The Provider Reimbursement Review Board ("Board") has reviewed the two (2) above-referenced optional groups relating QRS CY 2006 DSH Medicare Managed Care Part C Days and each group contains the same two participants. The issue in these 2 CIRP groups is governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R. Under the terms of this Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020). However, prior to issuing a remand for these groups, the Board finds a jurisdictional impediment with regard to the same two participants in both groups. The background of these groups, the pertinent facts with regard to the two participants and the Board's determination are set forth below.

Background:

On October 28, 2019, Quality Reimbursement Services ("QRS") filed appeal requests for the two above-referenced QRS 2006 Part C optional group appeals. Both groups were fully formed on October 28, 2020 and both have the same two participants that were directly added to the appeals from receipt of their revised Notices of Program Reimbursement ("RNPRs"):

- Waterbury Hospital (Prov. No. 07-0005) and
- Stamford Hospital (Prov. No. 07-0006)

In both groups, ***both*** participants included a statement indicating that the RNPRs were *not* issued as a result of a reopening. Further, ***both*** participants reference Audit Adjustment Nos. 3 and 5 for

both the SSI Fraction and Medicaid Fraction Part C days issues. For both Providers, Audit Adjustment Nos. 3 and 5 each state the exact same description:

> To adjust the SSI ratio and resulting change in DSH DPP in accordance with the remand of case number 09-1003G and CMS Ruling 1498-R and 1498-R2.

The Board records indicate that the Board remanded Case No. 09-1003G for the SSI *Baystate* data match issue pursuant to a standard 1498-R remand. However, the RNPRs do not reflect any change to the SSI Percentage on the RNPR audit adjustment reports in either of these adjustments for either Provider (*i.e.*, the "previous value" and the "new value" were the same and hence the "difference" was "0.00" resulting in no change in the SSI fraction). Specifically, for Waterbury Hospital, the initial value and the new value for the percentage of SSI recipient patient days to Medicare Part A days both show 4.51 and the DSH remained at 4.03 and, as a result, there was no change in the SSI fraction (*i.e.*, 0.00 difference). Similarly, for Stamford Hospital, the percentage of SSI recipient patient days to Medicare Part A days remained at 4.47 and the DSH remained at 3.66 and, as a result, there was not revision to the SSI fraction (*i.e.*, 0.00 difference).

Board Decision:

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

A. Relevant Regulations – Revised NPRs

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2019), which provides in relevant part:

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

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

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

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

Accordingly, pursuant to 42 C.F.R. § 405.1889(b) (and § 405.1835(a)(1) which references that regulation), the Board has jurisdiction only over those matters that have been "specifically revised" in a revised determination. More specifically, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised."[1]

Here, the Board finds that it does not have jurisdiction over Waterbury Hospital and Stamford Hospital as participants in these groups. The Providers both appealed from RNPRs, but there was no change in the adjustments to the SSI and DSH percentage for either Provider. The reference to CMS Rulings 1498-R and 1498-R2 confirms that the RNPRs in these groups were issued as a result of a 1498-R/1498-R2 remand. However the fact that CMS Ruling 1498-R/1498-R2 prompted the reopening and issuance of the RNPRs has no bearing here. First, the Board notes that, since the fiscal years at issue here concern 2006, Ruling 1498-R2 is clearly not applicable as it was a modification to Ruling 1498-R and only concerned discharges prior to October 1, 2004. Second, Ruling 1498-R addresses three components, or issues, of the SSI fraction for which 1498-R "eliminate[d] any actual case or controversy":

1. "*[T]he Data Matching Process Used in Calculating the SSI Fraction*." The Ruling applied to then-pending appeals of this issue "challenging CMS's data matching process, which the agency uses in determining the SSI fraction by matching Medicare and SSI eligibility data." The seminal case dealing with this issue is *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008). As a result, this issue is sometimes referred to as the *Baystate* SSI data matching issue.

2. "*[T]he Exclusion from the DPP [i.e., disproportionate share percentage] of Non-Covered Inpatient Hospital Days for Patients Entitled to Medicare Part A, and Days for Which the Patient's Part A Inpatient Hospital Benefits were Exhausted*." The Ruling applied to "cost reports with discharges before October 1, 2004" for which hospitals have pending "appeals seeking inclusion in the DPP of inpatient days where the patient was entitled to Medicare Part A but the inpatient hospital stay was not covered under Part A" (e.g., exhausted days and Medicare secondary payor ("MSP")

[1] 42 C.F.R. § 405.1889(b)(1).

days).

3. "*[T]he Exclusion from the DPP of Labor/Delivery Room ["LDR"] Inpatient Days.*" The Ruling applied to "cost reporting periods beginning before October 1, 2009" for which hospitals have pending appeals "seeking inclusion of LDR inpatient days in the DPP regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour."

The only issues covered by Ruling 1498-R that could be applicable to Waterbury Hospital and Stamford Hospital for FY 2006 are the *Baystate* data match process issue or Labor/Delivery Room Days and, as noted above, the Board's records indicate that the remand only concerned the SSI *Baystate* data match issue. Regardless, it is clear that Ruling 1498-R did ***not*** include or address the Part C days issue.[2] Accordingly, the Board concludes that Ruling 1498-R did not apply to SSI Medicare Part C days issues and, thus, the SSI Medicare Part C Days issue was outside the scope of Ruling 1498-R.[3] The Board recognizes that Ruling 1498-R states that a RNPR issued following a 1498-R remand ***of the Baystate SSI data matching issue*** "will be subject to administrative and judicial review in accordance with the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines." However, "the applicable jurisdictional and procedural requirements of . . . the Medicare regulations" includes 42 C.F.R. § 405.1889 and, as discussed above, this regulation limits Board jurisdiction to "those matters that are specifically revised." Here, it is clear that the Part C days issue was both outside the scope of 1498-R and not "specifically" revised in the RNPR at issue for Waterbury Hospital and Stamford Hospital.[4]

The only manner in which the Board has determined that it has jurisdiction over the Part C days issue *in the context of a RNPR* is if: (1) the SSI percentage is specifically adjusted for Part C Days; ***or*** (2) the data match process is rerun and generates a new and different SSI percentage where the Board must necessarily assume that there was a change in the underlying month-by-month data and that the Part C days included in that month-by-month data also were changed.[5]

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[2] In other words, a provider could appeal the Part C days issue from their original NPR and CMS Ruling 1498-R did not impact any Part C Days appeals.

[3] *See* CMS Ruling 1498-R at 18 (stating: "[I]f the administrative tribunal finds that a given claim is outside the scope of the Ruling (because such claim is not for one of the three DSH issues) or the claim fails to meet the applicable jurisdictional and procedural requirements for relief under the Ruling, then the appeals tribunal will issue a written order, briefly explaining why the tribunal found that such claim is not subject to the Ruling. The appeals tribunal will then process the provider's original appeal of the same claim in accordance with the tribunal's usual, generally applicable appeal procedures.").

[4] Further, the Board notes that, if the issue in this appeal had pertained to the *Baystate* data match process issue (as opposed to the Medicaid Fraction Part C days issue), the situation would be very different and the Board would have jurisdiction over it pursuant to Ruling 1498-R and 42 C.F.R. § 405.1889(b). In that scenario, while the provider's RNPR would have no adjustments, the provider would be trying to resume their original PRRB appeal of the *Baystate* SSI data match process issue (which the Ruling had eliminated and required the Board to remand) and would be dissatisfied with the intervening application of a new data match process (as mandated by Ruling 1498-R) that did not change their SSI fraction (*i.e*, they would be dissatisfied that the mandated new data matching process did not result in a change to their SSI fraction due to flaws in that new data matching process).

[5] This second situation does ***not*** encompass a realignment of the SSI percentage because CMS does ***not*** rerun the data match process in order to effectuate a realignment but rather uses pre-existing data previously gathered on a month-by-month basis to effectuate the realignment. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-

Here, the SSI percentages clearly were not adjusted for Part C days and, unless there is evidence to the contrary (which there is not), the Board must presume the underlying Part C days data was not changed since there were no changes in the SSI percentages themselves.[6] Accordingly, if Waterbury Hospital and Stamford Hospital wished to appeal or contest the Part C days issue for FY 2006, they should have appealed the issue from their original NPRs when they clearly had the right to do so since appeals of any potential future RNPRs are limited to matters "specifically revised."[7]

In summary, because there were no revisions to the SSI percentages for either Provider, the audit adjustments associated with the RNPRs do not meet the requirements of the regulation for Board jurisdiction of matters revised in a RNPR and the Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[8] Therefore, the Board dismisses Waterbury Hospital and Stamford Hospital from these groups pursuant to 42 C.F.R. § 405.1889.

Additionally, Waterbury Hospital, did file an appeal of its Part C days issue from its original NPR, to which the Board has *already* granted EJR, in 09-0996G and 09-0993G. Therefore, this

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by-month basis); 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] The Board is aware of situations in which a provider was subject to a 1498-R remand but, *prior to that remand being effectuated*, the provider received an unrelated reopening and was issued a RNPR with the new SSI percentage resulting from the new data match process, thereby rendering the later 1498-R effectuation perfunctory with a "0.00" adjustment.

[7] For context, the Board takes administrative notice that:

1. The final rule establishing the Agency's current policy on treatment of Part C days in the SSI fraction (and the one at issue in this case) was issued on August 11, 2004 and the Agency's Part C days policy, both prior to and following the August 11, 2004 final rule, has been subject to much litigation. *See, e.g*., *Northeast Hosp. Corp.v. Sebelius*, 699. Supp. 2d 81 (D.D.C. 2010), *aff'd by*, 657 F.3d 1 (D.C. Cir. 2011); *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012), *aff'd by*, 746 F.3d 1102 (D.C. Cir. 2014); *King & Spalding Inclusion of Medicare Advantage Days in 2007 SSI Ratios v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D38 (June 29, 2010) (This "D-" decision is an EJR determination. The Board does not routinely publish EJR determinations as "D-" decisions and will do so only when the EJR determination is *seminal*.).
2. Most providers filing Board appeals of the Part C days issue have done so by appealing from their original NPR, regardless of whether that NPR was issued prior to or after 1498-R (including certain appeals filed pre- 2010 in which the provider later requested bifurcation of the Part C days issue from dual eligible days issues emanating from the same August 11, 2004 final rule).

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

appeal is a duplicate of those appeals, that have already been adjudicated and are presumably already in Federal Court. This serves as an alternative rational to dismiss Waterbury. While the Board has not been able to locate an original NPR appeal of the Part Days for Stamford Hospital, it is quite possible that Stamford filed into a group appeal for that issue as well.

As there are no other participants in either group, the Board closes Case Nos. 20-0247G and 20-0249G and removes them from the docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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For the Board:

6/22/2021

X Clayton J. Nix

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

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination***
University of Missouri Healthcare (Prov. No. 26-0141)
FYE 6/30/17
Case No. 21-1350

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's June 7, 2021 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:

> . . .the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Provider asserts that] [t]he regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the statute because it determines the cap after application of weighting factors.[1]

Background

The Medicare statute requires the Secretary[2] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME"). [3] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[4]

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

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[1] Provider's EJR request at 1.
[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395ww(h).
[4] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[5]

This appeal concerns the first component of the DGME payment calculation—the resident FTE count.

A hospital's FTE count for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[6] ("*IRP residents*") are weighted at 100 percent or 1.0, while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "*fellows*") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[7] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents

[5] 42 U.S.C. § 1395(h).
[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

> before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[9] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> • *Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .

[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[9] 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.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 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.[12]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[13] This regulation is the focus of these appeals and this EJR request, and it states the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

As previously noted, this regulation addresses how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility that year.[15]

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

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[12] *Id.* at 39894 (emphasis added).
[13] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that were in the prior version of the regulation and replacing them with reference to "the limit described in this section."
[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[16]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, is averaged with the FTE counts from the prior and penultimate years.

The Provider's Position

The Provider asserts that the MAC's calculations of the current, prior-year and penultimate-year DGME FTES and the FTE caps are contrary to the statutory provisions at 42 U.S.C. § 1395ww(h), and, as a result, the Provider's DGME payments are understated. The Provider contends that the regulation implementing the cap and the weighting factors is contrary to the statute because it determines the cap after the application of the weighting factors.[17] The effect of this regulation is to impose on the Provider weighting factors that result in reductions greater than 0.5 for many residents who are beyond the IRP, and the regulation prevents the Provider from claiming and receiving reimbursement for their full unweighted FTE caps.[18]

The Provider explains that the Medicare statute caps the number of residents that a hospital can claim at the number it trained in cost years ending in 1996.[19] The statute states that, for residents beyond the IRP, "the weighting factor is .50."[20] The statute also states that the current year FTEs are capped before application of the weighting factors: "the total number of full-time equivalent residents before application of the weighting factors . . . may not exceed the number . . . of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996."[21] The Provider concludes that this statutory scheme sets an absolute weighting factor on fellows of 0.5 and requires that the weighting factors are not applied when capping the current year FTEs.

The Provider claims that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[22] Instead, a weighted FTE cap is determined for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE(UCAP/UFTE) = WCap,[23] is applied to the weighted FTE count in the current year which

[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[18] 42 C.F.R. § 413.79(c)(2).
[19] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[20] *Id.* at § 1395ww(h)(4)(C)(iv).
[21] *Id.* at 1395ww(h)(4)(F)(i).
[22] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[23] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.

creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Provider contends that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[24]

Second, the Provider posits, the weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The Provider explains that the downward impact on the FTE count increases as hospital trains more residents beyond the IRP and the problem increase as a hospital trains more fellows because the methodology amplifies the reduction.

Third, in some situations, as demonstrated by the Table on page 12 of the Provider's EJR request, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Provider points out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled providers to claim FTEs up to that cap.

The Provider concludes that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion. Since, the Board lacks the authority to grant the relief sought, the request for EJR should be granted.

Decision of the Board

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

A. Compliance with requirements for filing a Board appeal

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

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

[24] *Id.* at §1395(h)(4)(F)(i).

> shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .[25]

In this case, the Provider, which filed this case from the Medicare Contractor's failure to issue a timely final determination, filed a timely appeal.

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

The Provider which appealed from a cost reporting period beginning on or after January 1, 2016, and is subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[26] Specifically, effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[27]

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"[28] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument)

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

if a party to the appeal questions whether there was an appropriate claim made.[29] As no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[30] 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.[31] 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).

In addition, the participant's documentation in the EJR requests shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal.[32] The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

C. Board's Analysis of the Appealed 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. Specifically, the Provider presents the following equation in their request for EJR used to calculate the allowable count for primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

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

Accordingly, the Board set 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

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[29] *See* 42 C.F.R. § 405.1873(a).
[30] 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."
[31] Although no question was raised in this appeal regarding whether an appropriate claim was made, the Board recognizes that the Provider's cost report affected by these regulations included a claim for the disputed DGME payment as a protested amount in their as-filed cost reports as evidenced in the jurisdiction documentations found in the Office of Hearings Computer Docketing and Management System (OHCDMS) for the Provider. The Provider included a summary of their Protested amounts which included the DGME calculation and a copy of Worksheet E-4 which demonstrated the Providers claimed DGME reimbursement.
[32] *See* 42 C.F.R. § 405.1835.
[33] EJR Request at 4.

Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[34] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[35] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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 in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[36]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[37] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[38] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the

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[34] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).

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

[36] (Emphasis added.)

[37] *See* 62 Fed. Reg. at 46005 (emphasis added).

[38] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).

FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[39] (*i.e.*, ratios) using variables a, b, c, and d:

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

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[40]

On the other side of the algebraic equation (*i.e.*, the ratio of "c / d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same proportion." This phrase expressed as a ratio ("c/d") is an *unknown* Weighted FTE Cap over the FY's Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

$$\frac{Weighted\ FTE\ Cap\ (c)}{FY's\ Weighted\ FTE\ Count\ (d)} = \frac{Unweighted\ \ FTE\ Cap\ (a)}{FY's\ Unweighted\ FTE\ Count\ (b)}$$

The unknown Weighted FTE Cap (variable "c") is then determined by a/b x d. In other words, the unknown Weighted FTE Cap is determined by the following formula:

$$\boldsymbol{Weighted\ FTE\ cap} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times\ Weighted\ FTE\ Count$$

This formula is clearly stated in the preambles to both the FYs 1998 and 2002 IPPS Final Rules as previously quoted.

Based on the above, the Board finds that 42 C.F.R. § 413.79(c)(2)(iii) does set forth the equation being challenged and, accordingly, that the 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

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[39] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

[40] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

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 this case.

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the participant in this appeal is entitled to a hearing before the Board;

2) Based upon the participant's assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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FOR THE BOARD:

6/22/2021

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RE: ***Jurisdictional Determination on Two Participants***
SRI Presence FY 2007 Medicaid Fraction Part C Days
Case No. 14-1554GC
Participants under Prov. Nos. 14-0155, 14-0251

Dear Mr. Roth and Mr. Pike,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in preparation for remand of the appeal pursuant to CMS Ruling 1739-R . The Board's decision is set forth below.

Background:

The Provider Reimbursement Review Board (the "Board") received the Providers Request for Hearing dated December 5, 2013, which included a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013.

This issue is governed by Ruling CMS-1739-R and, under the terms of this Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule.

In its review of the jurisdictional documentation for the remand in the above case, the Board identified issues with two providers: Provena St. Mary's Hospital (14-0155) ("St Mary's"), and Our Lady of the Resurrection (14-0251) ("Resurrection"). [1]

A. Provena St. Mary's Hospital (Prov. No. 14-0155)

St. Mary's appealed from a Revised Notice of Program Reimbursement dated February 20, 2013. The Provider appealed from a revised NPR but failed to include the audit adjustment report or Notice of Reopening with the Schedule of Providers as required for

[1] Participant Numbers 3 and 7 on the attached Schedule of Providers.

revised NPR appeals pursuant to Board Rules 7.1.2.1 and 21.2.2. This documentation is necessary in order for the Board to determine jurisdiction over such revised NPR appeals under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1). Therefore, the Board is unable to determine if Part C days in the SSI Percentage were adjusted in the revised NPR.

B. Our Lady of the Resurrection (Prov. No. 14-0251)

Resurrection appealed Audit Adjustment Nos. 4 and 6 which state:

> Audit Adjust. No. 4: "To adjust the SSI % and DSH % to audited amounts in accordance with PRM-2, Section 3630.1, 42 CFR 412.106ff, ***and 1498-R***"[2]
>
> Audit Adjust. No. 6: "To update the SSI % for Capital DSH ***in accordance with CMS Ruling 1498-R***"[3]

Accordingly, these audit adjustments were clearly made pursuant to remand via CMS Ruling 1498R. However, these audit adjustments show that the SSI fraction did not change as the previous value was 8.02 and it remained 8.02 with 0.00 difference.

Board Determination

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

Relevant Regulations – RNPRs

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2011) provides in relevant part:

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

42 C.F.R. § 405.1889 (2011) explains the effect of a cost report revision:

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

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

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over the two above mentioned Participants from their revised NPRs, as there is no evidence that the Part C days in the SSI/Medicare fraction was "specifically" adjusted in the Provider's revised NPR.

The revised NPR regulations make clear that a Provider can only appeal items that are "specifically" adjusted from a revised NPR. Here, the Board finds that it does not have jurisdiction over Part C days in the SSI or Medicaid fractions, as there is no evidence those days were adjusted in the respective RNPRs as required by 42 C.F.R. § 405.1889.

With respect to Provena St. Mary's Hospital (14-015), the Board notes that the Provider failed to include the audit adjustment report or Notice of Reopening with the Schedule of Providers as required for revised NPR appeals pursuant to Board Rules 7.1.2.1 and 21.2.2. This documentation is necessary in order for the Board to determine jurisdiction over such revised NPR appeals under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1). Therefore, the Board is unable to determine if Part C days in the SSI Percentage were adjusted in the revised NPR.

With respect to Our Lady of the Resurrection (14-0251), the Provider appealed from a revised NPR but there was no change in the adjustment to the SSI and DSH percentages. Audit Adjustment Nos. 4 and 6 (as quoted above) make clear that the revised NPR was issued as a result of a 1498-R remand. More specifically, while the documents included in the transfer request for Our Lady of the Resurrection does not include a copy of the Notice of Reopening that

resulted in the revised NPR at issue (as required under Board Rules 7.1.2.1 and 21.2.2), the reference to CMS Ruling 1498-R confirms that the revised NPR was issued as a result of a 1498-R remand. However, the fact that CMS Ruling 1498-R may have prompted the reopening and issuance of the revised NPR at issue has no bearing here. The three components, or issues, of the SSI fraction addressed by 1498-R and for which 1498-R "eliminate[d] any actual case or controversy" were:

1. "*[T]he Data Matching Process Used in Calculating the SSI Fraction*." The Ruling applied to then-pending appeals of this issue "challenging CMS's data matching process, which the agency uses in determining the SSI fraction by matching Medicare and SSI eligibility data." The seminal case dealing with this issue is *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008). As a result, this issue is sometimes referred to as the *Baystate* SSI data matching issue.

2. "*[T]he Exclusion from the DPP [i.e., disproportionate share percentage] of Non-Covered Inpatient Hospital Days for Patients Entitled to Medicare Part A, and Days for Which the Patient's Part A Inpatient Hospital Benefits were Exhausted*." The Ruling applied to "cost reports with discharges before October 1, 2004" for which hospitals have pending "appeals seeking inclusion in the DPP of inpatient days where the patient was entitled to Medicare Part A but the inpatient hospital stay was not covered under Part A" (e.g., exhausted days and Medicare secondary payor ("MSP") days).

3. "*[T]he Exclusion from the DPP of Labor/Delivery Room ["LDR"] Inpatient Days.*" The Ruling applied to "cost reporting periods beginning before October 1, 2009" for which hospitals have pending appeals "seeking inclusion of LDR inpatient days in the DPP regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour."

The only issues covered by Ruling 1498-R that could be applicable to Our Lady of Resurrection Medical Center for FY 2007 is the *Baystate* data match process issue or Labor/Delivery Room Days. However, 1498-R clearly does ***not*** include the Part C days issue.[4] As a result, the only manner in which the Board has determined that it has jurisdiction over the Part C days issue *in the context of a revised NPR* is if: (1) the SSI percentage is specifically adjusted for Part C Days; ***or*** (2) the data match process is rerun and generates a new and different SSI percentage where the Board must necessarily assume that there was a change in the underlying month-by-month data and that the Part C days included in that month-by-month data also were changed.[5] Here,

[4] In other words, a provider could appeal the Part C days issue from their original NPR and CMS Ruling 1498-R did not impact any Part C Days appeals. Here, it appears as if Our Lady of Resurrection Medical Center opted not to appeal the Part C days issue from its original NPR for FY 2007. *See infra* note 3.

[5] This second situation does ***not*** encompass a realignment of the SSI percentage because CMS does ***not*** rerun the data match process in order to effectuate a realignment but rather uses pre-existing data previously gathered on a month-by-month basis to effectuate the realignment. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data

the SSI percentage clearly was not adjusted for Part C days and, unless there is evidence to the contrary (which there is not), the Board must presume the underlying Part C days data were not changed since there was no change in the SSI percentage itself.[6] In this regard, the Board notes that the Provider is challenging the regulation promulgated in the August 11, 2004 final rule that requires these Part C days to be counted in the SSI fraction and there is no dispute about the amount or number of Part C days included in the SSI fraction itself.

Accordingly, if Our Lady of Resurrection Medical Center wished to appeal or contest the Part C days issue for FY 2007, it should have appealed that issue from its original NPR when it clearly had the right to do so since appeals of any potential future revised NPRs is limited to matters "specifically revised."[7] In this regard, the Board notes that Ruling 1498-R did not apply to SSI Medicare Part C days issues and, thus, the SSI Medicare Part C Days issue was outside the scope of Ruling 1498-R.[8] The Board recognizes that Ruling 1498-R states that a revised NPR issued following a 1498-R remand ***of the Baystate SSI data matching issue*** "will be subject to

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on a month-by-month basis); 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[6] The Board is aware of situations in which a provider was subject to a 1498-R remand but, *prior to that remand being effectuated*, the provider received an unrelated reopening and was issued a revised NPR with the new SSI percentage resulting from the new data match process, thereby rendering the later 1498-R effectuation perfunctory with a "0.00" adjustment.

[7] For context, the Board takes administrative notice that:

1. The final rule establishing the Agency's current policy on treatment of Part C days in the SSI fraction (and the one at issue in this case) was issued on August 11, 2004 and the Agency's Part C days policy, both prior to and following the August 11, 2004 final rule, has been subject to much litigation. *See, e.g*., *Northeast Hosp. Corp. v. Sebelius*, 699. Supp. 2d 81 (D.D.C. 2010), *aff'd by*, 657 F.3d 1 (D.C. Cir. 2011); *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012), *aff'd by*, 746 F.3d 1102 (D.C. Cir. 2014); *King & Spalding Inclusion of Medicare Advantage Days in 2007 SSI Ratios v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D38 (June 29, 2010) (This "D-" decision is an EJR determination. The Board does not routinely publish EJR determinations as "D-" decisions and will do so only when the EJR determination is *seminal*.).
2. Most providers filing Board appeals of the Part C days issue have done so by appealing from their original NPR, regardless of whether that NPR was issued prior to or after 1498-R (including certain appeals filed pre-2010 in which the provider later requested bifurcation of the Part C days issue from dual eligible days issues emanating from the same August 11, 2004 final rule).

[8] *See* CMS Ruling 1498-R at 18 (stating: "[I]f the administrative tribunal finds that a given claim is outside the scope of the Ruling (because such claim is not for one of the three DSH issues) or the claim fails to meet the applicable jurisdictional and procedural requirements for relief under the Ruling, then the appeals tribunal will issue a written order, briefly explaining why the tribunal found that such claim is not subject to the Ruling. The appeals tribunal will then process the provider's original appeal of the same claim in accordance with the tribunal's usual, generally applicable appeal procedures.").

administrative and judicial review in accordance with the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines." However, "the applicable jurisdictional and procedural requirements of . . . the Medicare regulations" includes 42 C.F.R. § 405.1889 and, as discussed above, this regulation limits Board jurisdiction to "those matters that are specifically revised." Here, it is clear that the Part C days issue was both outside the scope of 1498-R and not "specifically" revised in the revised NPR at issue for Our Lady of Resurrection Medical Center.[9]

Based on the above findings, the Board hereby ***dismisses*** Provena St. Mary's Hospital (14-015), and Our Lady of the Resurrection (14-0251) from the CIRP group case. The Board will remand the CIRP group case pursuant to CMS Ruling 1739-R under separate cover.

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

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For the Board:

6/22/2021

X Clayton J. Nix

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

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

[9] Further, the Board notes that, if the issue in this appeal had pertained to the *Baystate* data match process issue (as opposed to the Part C days issue), the situation would be very different and the Board would have jurisdiction over it pursuant to Ruling 1498-R and 42 C.F.R. § 405.1889(b). In that scenario, while the provider's revised NPR would have no adjustment, the provider would be trying to resume its original PRRB appeal of the *Baystate* SSI data match process issue (which the Ruling had eliminated and required the Board to remand) and would be dissatisfied with the intervening application of a new data match process (as mandated by Ruling 1498-R) that did not change to its SSI fraction (*i.e*, it would be dissatisfied with the mandated new data matching process did not result in a change to its SSI fraction due to flaws in that new data matching process).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Decision***
Case No. 18-0310 – Catawba Valley Medical Center, Prov. No. 34-0143, FYE 06/30/14
Case No. 19-0655 – Houston Medical Center, Prov. No. 11-0069, FYE 12/31/13
Case No. 19-1920 – Univ. of Michigan Hosps. & Health Ctrs., Prov. No. 23-0046, FYE 06/30/14
Case No. 20-0169 – Grady Memorial Hospital, Prov. No. 11-0079, FYE 12/31/12
Case No. 20-1754 – North Memorial Medical Center, Prov. No. 24-0001, FYE 12/31/13

Dear Ms. Webster and Mr. Richards:

The above -referenced five (5) individual appeals include a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges ***before*** October 1, 2013. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On May 24, 2021, the Providers in the above-referenced appeals filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Request, and then grant it in part and deny it in part, is set forth below.

Statutory and Regulatory Background

A. Medicare Advantage Program

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

Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[1] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[2]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[3]

With the creation of Medicare Part C in 1997,[4] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[5]

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

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[1] of Health and Human Services.
[2] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[3] *Id.*
[4] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[5] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

> [o]nce a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A.
>
> *. . . once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.*[6]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[7] In response to a comment regarding this change, the Secretary explained that:

> [*W]e do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction.*
>
> *Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . .* if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[8]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[9] In that publication, the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§

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[6] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[7] 69 Fed. Reg. at 49099.
[8] *Id.* (emphasis added).
[9] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[10] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[11]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[12] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[13] In *Allina Health Services v. Price* ("*Allina II*"),[14] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[15] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[16] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[17]

B. CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued Ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[18] Further, the Ruling requires that the Board remand any otherwise

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[10] *Id*. at 47411.
[11] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[12] 746 F. 3d 1102 (D.C. Cir. 2014).
[13] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[14] 863 F.3d 937 (D.C. Cir. 2017).
[15] *Id.* at 943.
[16] Id. at 943-945.
[17] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[18] CMS Ruling 1739-R (Aug. 17, 2020).

jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[19] The Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[20]

Regarding EJRs for this Issue, and the fate of these appeals, the ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule 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 Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[21]

[19] *Id*.
[20] *Id*.
[21] CMS Ruling 1739-R at 6-7.

Providers' Request for EJR

The Providers point out that the Secretary has not acquiesced to the D.C. Circuit's rulings in *Allina I*[22] and *Allina II*[23] or the Supreme Court's decision in *Allina II* affirming the D.C. Circuit's decision. The Providers contend that the uncorrected DSH payment determinations applying the now-vacated rule (and the payment standard embedded in it) as though it is still valid not only violates the explicit terms of the *Allina* decisions, but also violates the procedural requirements of the Medicare Act, 42 U.S.C. § 1395hh(a), and the Administrative Procedure Act ("APA"), 5 U.S.C. § 553. The Providers seek corrections of those payment determinations. The Providers maintain that the Secretary has left on the books the vacated 2004 rule itself (in addition to the Part A/SSI fractions published based on this rule) which the Board is bound to apply under the provisions of 42 C.F.R. § 405.1867. The Providers contend the Board has jurisdiction over the appeals but lacks the authority to grant the relief sought by the Providers; consequently, the Board is required to grant EJR.[24]

The Providers maintain recent developments reinforce the Board's lack of authority to resolve this issue and the need for EJR. The Providers contend the agency's proposed rule to re-adopt the 2004 policy change retroactively is still only a proposal at this point. If the Agency adopts this proposal as final, which the Providers believe CMS Ruling 1739-R seems to presume would occur in claiming that the pending appeals are now "moot," the payment determinations from which the Providers have appealed would be left undisturbed (and potentially not subject to appeal). The Providers assert CMS Ruling 1739-R calls for the Board to determine its jurisdiction over Part C appeals and does not and cannot override the Board's obligation to make determinations as to its authority to decide legal questions. The Providers contend, in any event, the Ruling is invalid as it otherwise violates the clear requirements of the Medicare statute and regulations which the agency cannot circumvent by issuing a ruling.[25]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.
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> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself

[22] *Allina Health Servs. v. Sebelius*, 746 F. 3d 1102 (D.C. Cir. 2014) (*Allina I)*.
[23] *Allina Health Servs. v. Price,* 863 F. 3d 937 (D.C. Cir. 2017), aff'd *Azar v. Allina Health Servs.* 139 S. Ct. 1804 (2019) ("*Allina II"*).
[24] Providers' EJR Request at 1-2.
[25] *Id.* at 2.

> acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[26]
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> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over the DSH Part C appeals at issue here. . . . [T]he Providers have submitted supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of the subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[27]

The Providers also maintain that the Board has jurisdiction over the Providers' challenge to the validity and proper application of CMS Ruling 1739-R as part of the matter at issue. The Providers argue that while the Ruling ordered the Board to remand otherwise jurisdictionally proper appeals of the Part C days issue, it does not by its terms deprive the Board of jurisdiction over the challenges to the actual validity of the Ruling. The Providers believe the Board was correct in its decision in *Southwest Consulting 2004 DSH Dual Eligible Days Group et al. v. Blue Cross Blue Shield Association*[28] when it found in the context of analogous CMS Ruling 1498-R,[29] "EJR is appropriate to determine the validity in [the Ruling] that would, if valid, deprive the Board of jurisdiction and thereby prohibit it from granting EJR as to the validity of other substantive provisions [of the Ruling]."[30]Accordingly, the Providers assert the Board was correct when it concluded it has jurisdiction over appeals that challenge the validity of CMS Ruling 1739-R in earlier cases that challenged the validity of Ruling 1498-R.[31]

The Providers maintain the issue in this appeal for North Memorial Medical Center, Provider No. 24-0001, Case No. 20-1754, concerns the appropriate treatment of Part C days in the DSH

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[26] *Id.* at 16.
[27] *Id.* at 19.
[28] PRRB Dec. 2010-D35 (2010 WL 4214212 (PRRB) (June 14, 2010)).
[29] The Ruling is found on the internet at: https://www.cms.gov/regulations-and-guidance/guidance/rulings/downloads/cms1498r.pdf.
[30] PRRB Dec. 2010-D35 at 5.
[31] Providers' EJR Request at 21.

calculation for periods both before and after the October 1, 2013 rule change.[32] The Providers assert North Memorial requests EJR over only the portion of its appeal challenging the application of the agency's 2004 rule to its Medicare part A/SSI fractions and Medicaid discharges reflected in the Medicaid fraction prior to October 1, 2013, and not to the portion subject to the October 1, 2013 rule raising legal questions distinct from those raised for prior periods.[33] The Providers contend North Memorial's cost year began in federal fiscal year ("FFY") 2013. Thus, its challenge to the Medicare part A/SSI fractions and to the exclusion of Medicaid eligible part C days from the Medicaid fraction for any patients discharged before October 1, 2013, is governed by the 2004 rule.[34]

The Providers maintain EJR is appropriate because the Board has jurisdiction over the issue raised in these appeal, the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue, yet the Board does not have the authority to grant the relief from those determinations sought by the Providers.[35] The Providers assert because the Secretary has not acquiesced in the binding decisions of the D.C. Circuit and the Supreme Court, the Board remains bound by the 2004 rule and thus, still lacks authority to grant relief from the determinations applying the 2004 rule.[36] The Providers contend because CMS Ruling 1739-R purports to deprive the Board of its jurisdiction to hear the Providers' appeals over this issue, the validity and proper application of that Ruling to these appeals are also properly before the Board as part of the matter at issue.[37] The Providers maintain the agency has interpreted its procedural obligations under binding Supreme Court and D.C. Circuit precedent, the Medicare Act, and the APA incorrectly and the Providers seek relief from that invalid interpretation that the Board is without power to grant. The Providers argue given that the Board has jurisdiction over the issue but lacks the authority to grant the relief sought by the Providers, EJR must be granted.[38]

Board's Analysis and Decision

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is the Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage. The first issue is the ***substantive issue*** and the source of the Providers' dissatisfaction.

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[32] The appeals challenging the post October 1, 2013 periods for the remaining hospitals in this EJR request have already been bifurcated and are pending in separate appeals. Catawba Valley Medical Center (Provider No. 34-0143, FYE 6/30/14, Case No. 18-0310) in case number 18-1214G, Houston Medical Center (Provider No. 11-0069, FYE 12/31/13, Case No. 19-0655) in Case No. 19-0689GC, and University of Michigan Hospitals & Health Centers (Provider No. 23-0046, FYE 6/30/14, Case No. 19-1920) in case number 20-0495G.
[33] Providers' EJR Request at 3.
[34] *Id.* at 5.
[35] *Id.* at 14.
[36] *Id.* at 2.
[37] *Id.* at 14.
[38] *Id.* at 15.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that, as of August 17, 2020, divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020.

A. Board's Authority

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) 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.

B. Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. 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 for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[39,40]

1. Jurisdictional Challenge – Catawba Valley Medical Center

a. Medicare Contractor's Jurisdictional Challenge

The Medicare Contractor asserts the pre-10/1/13 Part C days issue for Catawba Valley Medical Center ("Catawba") was untimely and improperly added.[41] The Medicare Contractor contends the Provider's initial NPR was issued on June 7, 2017, and the Provider timely filed its appeal request on December 1, 2017 (177 days). The Medicare Contractor maintains that it received the Provider's preliminary position paper, which added the ***pre***-10/1/13 Part C days issue, on July 27, 2018. The Medicare Contractor maintains this is 415 days after the Provider received the NPR which is over the 240 day period the Provider had to add an issue to its existing appeal.

The Medicare Contractor asserts the Provider's appeal request was very specific to Part C days for discharges occurring ***on or after*** October 1, 2013. The fact that the Provider included a protest amount for the entire cost reporting period on its cost report does not establish a valid appeal for the entire year. The Medicare Contractor argues the fact that an item was protested

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[39] 42 C.F.R. § 405.1835(a).
[40] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[41] Medicare Contractor's Jurisdictional Challenge at 2.

does not mean that a Provider will subsequently file an appeal for that issue, nor does that protest amount hold open the time period to file an appeal indefinitely. The Medicare Contractor contends if the Provider had meant to appeal the Part C days for the entire year, it should not have included specific verbiage in its appeal request to differentiate the discharge date or it should have requested two separate issues to differentiate between the regulations governing the Part C days or it should have filed the proper and timely request to add an issue to its existing appeal.

The Medicare Contractor maintains the Provider's Representative also formed group appeal, CN: 18-1214G, Akin Gump 2014 Post-9/30/2013 DSH Medicare Advantage Days Group, to which issue 1, the Part C days issue was transferred. The Medicare Contractor notes that the entire amount of controversy of this issue was transferred and listed on the Schedule of Providers for the group appeal, CN: 18-1214G. The Medicare Contractor argues this indicates the Provider was not bifurcating this issue into pre and post 9/30/13 periods when the post 9/30/13 group appeal was formed on April 19, 2018.[42] The Medicare Contractor asserts the Provider has failed to meet the timeliness requirement set forth in 42 C.F.R. §§ 405.1835(a)(3) and 405.1835(e)(3). The Medicare Contractor requests the Board dismiss the pre 10/1/13 Part C days issue and this case as all timely added issues have already been transferred to group cases.[43]

b. Provider's Response to Medicare Contractor's Jurisdictional Challenge

Catawba contends that it protested the Secretary's treatment of Part C days in the DSH calculation in its as-filed cost report for the FYE June 30, 2014, and timely appealed the adjustments removing those protested items. The Provider maintains that is more than enough to establish jurisdiction under 42 U.S.C. § 1395oo and the related regulation in 42 C.F.R. § 405.1835 and that the Medicare Contractor's jurisdictional challenge to Part C days with respect to discharges occurring prior to October 1, 2013 should be denied.[44]

The Provider asserts there is no question that it protested and appealed the Medicare Contractor's adjustments removing the protest amount included on the as-filed cost report with respect to the treatment of Part C days in the DSH payment calculation. The Provider explains that the Model form submitted with its initial hearing request plainly expressed its intent to appeal the whole "DSH Part C days" issue, and its reimbursement impact calculation that accompanied its initial appeal filing included the full effect of the issue as it relates to all discharges before or after October 1, 2013.

The Provider contends in its as-filed cost report it protested the treatment of Part C days in the DSH calculation; its calculation of the protest amount reflected the addition of 713 Part C days relating to discharges before or after October 1, 2013. The Provider maintains that for discharges before October 1, 2013, it specifically protested the validity of the 2004 rule requiring that Part C days be included in the Medicare Part A/SSI fraction and Medicaid eligible portion of those patient days be excluded from the numerator of the Medicaid fraction and that the Medicare

[42] *Id.* at 3.
[43] *Id.* at 4.
[44] Provider's Response to Medicare Contractor's Jurisdictional Challenge at 1-2.

Contractor made adjustments removing the protested amounts related to the Part C days issue in Audit Adjustment numbers 15 and 16. The Provider explains that in an effort to facilitate possible future settlement of the Part C days issue in the individual appeal with respect to discharges occurring prior to October 1, 2013, it transferred its appeal of days for patients discharged on or after October 1, 2013, to CN: 18-1214G by letter dated April 19, 2018.

The Provider continues that it timely appealed the Part C days issue from the Medicare Contractor's determination by letter dated November 30, 2017. The Provider argues it appealed the treatment of Part C days in the DSH payment calculation for the entirety of its cost reporting period ending June 30, 2014 and points out that in its Appeal Request (Model Form A), it noted its appeal of the "DSH Part C days" issue and specifically appealed Audit Adjustments 15 and 16, the adjustments that removed the protested amounts for the "Hospital's Medicaid eligible days-Medicare Part C" and the "SSI percentage calculation." The Provider asserts the reimbursement impact calculation that accompanied the appeal request also reflected the same number of Part C patient days (713 days) that were protested on the cost report for all discharges in the entire cost reporting period.[45]

The Provider concludes that the Board properly has jurisdiction over the entire Part C days issue, including all Part C days for patients discharged before or after October 1, 2013.[46]

c. Board's Decision regarding Catawba Jurisdictional Challenge

Pursuant to 42 C.F.R. § 405.1835(a), a provider has a right to a Board hearing with respect to a final contractor or Secretary determination for the provider's cost reporting period, if it is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, the amount in controversy is $10,000 or more for an individual appeal, and the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination. Pursuant to § 405.1835(e)(3) a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board if the Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180 day period.

Here, the Board finds that Catawba timely appealed the entire Part C days issue, including all Part C days for patients discharged before ***or*** after October 1, 2013. The Board recognizes that the Provider's issue statement includes references to discharges on or after 10/1/13 instead of before or after 10/1/13. However, the Provider's fiscal year encompasses both pre- and post-10/1/2013 that are impacted by the 2004 and 2013 rulemakings respectively and, as a result, it would make sense that the Provider intended to appeal all aspects of the Part C days issue. This is borne out by the facts that the Provider's issue statement references both the 2004 and 2013 rulemakings addressing the Part C Days regulation at issue and, more importantly, does make clear that it was, without qualification, challenging the CMS's treatment of Medicare Advantage days and contending that ***all*** Medicare Advantage days should be excluded from the SSI fraction:

[45] *Id.* at 5-6.
[46] *Id.* at 16.

> The Provider challenges CMS's treatment of Medicare Advantage days in the determination of the Provider's DSH percentage for both operating and capital DHS. The Provider contends that ***all*** Medicare Advantage days should be excluded from the Medicare Part A/SSI fraction and the Medicaid-eligible portion of these days should be counted in the numerator of the Medicaid fraction.[47]

As noted by the Provider, this finding is further supported by the protested item that was appealed as the protested item included Medicare Advantage days pre- and post 10/1/2013. As such, the Board finds that the Provider timely appealed the pre-10/1/13 Part C days issue. The Board concludes that it has jurisdiction to hear the Provider's appeal and denies the Medicare Contractor's Jurisdictional Challenge.

2. *Jurisdiction for Remaining Providers*

With respect to the "dissatisfaction" prong of the Board's jurisdiction regulation, for cost report periods ending prior to December 31, 2008, a provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[48] 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.[49]

On August 21, 2008, new regulations governing the Board were effective.[50] 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*").[51] 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.[52]

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[47] (Emphasis added.)
[48] 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.).
[49] *Bethesda* at 1258-59.
[50] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[51] 201 F. Supp. 3d 131 (D.D.C. 2016).
[52] *Banner* at 142.

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R ("CMS 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods that ended on or after December 31, 2008, and began before January 1, 2016, that were pending or filed on or after April 23, 2018.[53] Under this Ruling, if 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) is no longer applicable. However, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.[54]

The Board finds the Providers in the instant EJR Request filed appeals from original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2012, 2013, and 2014 (but only as to patient discharges before October 1, 2013) and are governed by CMS Ruling CMS-1727-R.[55] The Board further finds that the Providers appeals are permitted under the dictates of CMS-1727-R because they self-disallowed their claims based on the regulation at issue and are challenging the validity of that regulation.

Finally, the Providers' documentation shows that the estimated amount in controversy exceeds $10,000 as required for individual appeals.[56] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount in each case.

C. Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[57] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[58] *i.e*., the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are 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

[53] CMS Ruling CMS-1727-R at 1-2.
[54] *Id*. at unnumbered page 7.
[55] Under Ruling 1727-R, 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.
[56] *See* 42 C.F.R. § 405.1835(a).
[57] (Emphasis added.)
[58] CMS Ruling 1739-R at 1-2.

from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[59] To date, CMS has yet to issue its new final rule.[60]

The Providers' appeals concern FYEs 12/31/12, 12/31/13, and 06/30/14 cost reporting periods and the EJR request relates ***only*** to patient discharges before October 1, 2013.[61] CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e*., the date CMS Ruling 1739-R was issued) as it relates to discharges prior to October 1, 2013. Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny the Providers' EJR requests concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[62]Accordingly, the Board will issue, under separate cover, a remand for the providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e*., determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

D. ***Validity of CMS Ruling 1739-R***

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over the DSH Part C group appeal at issue here. . . . [T]he Providers have submitted supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[63]

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[59] Id. at 2.
[60] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[61] The post October 1, 2013 cost reporting periods for Catawba Valley Medical Center (Prov. No. 34-0143, FYE 6/30/14, Case No. 18-0310), Houston Medical Center (Prov. No. 11-0069, FYE 12/31/13, Case No. 19-065), and University of Michigan Hospital & Health Centers (Prov. No. 23-0046. FYE 6/30/14, Case No. 19-1920), have already been bifurcated and are pending in separate appeals. Catawba Valley Medical Center in Case No. 18-1214G, Houston Medical Center in Case No. 19-0689GC, and University of Michigan Hospital & Health Centers in Case No. 20-0495G. North Memorial Medical Center (Provider No. 24-0001, FYE 12/31/13, Case No. 20-1754) is requesting EJR for the cost reporting period beginning January 1, 2013, through September 30, 2013 only. North Memorial Medical Center is not requesting EJR for the cost reporting period beginning October 1, 2013, through December 31, 2013. This cost reporting period remains under appeal.
[62] (Emphasis added.)
[63] Providers' EJR Request at 19.

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[64] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[65]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [66] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[67]

As noted prior, the Board must grant EJR 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.[68] Here, the Providers essentially challenge the Board's *application* of CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that, as of August 17, 2020, purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling,

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[64] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

[65] *See Southwest* at 6-7.

[66] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.

[67] *See* CMS 1739-R at 8.

[68] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

1) The Board concludes it has jurisdiction to hear the appeals of all providers within the above referenced appeals (*i.e*., the appeals are jurisdictionally proper);

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations for discharges prior to October 1, 2013. Rather, pursuant to CMS 1739-R, the Providers will receive a remand letter of this issue under separate cover; and

3) The Board hereby **grants** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that, as of August 17, 2020, divests the Board of substantive jurisdiction over the Medicare Part C Days issue for discharges prior to October 1, 2013 that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. 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 appeals.

Board Members Participating:

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FOR THE BOARD:

6/22/2021

X Clayton J. Nix

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

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc.
Cecile Huggins, Palmetto GBA
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RE: ***Jurisdictional Determination***
QRS CY 2007 DSH Medicaid Fraction Medicare Managed Care Part C Days (4) Group
Case No. 20-0243G

Dear Mr. Ravindran and Mr. Pike:

The Provider Reimbursement Review Board ("Board") has reviewed the QRS CY 2007 DSH Medicaid Fraction Medicare Managed Care Part C Days (4) Group. The issue in this optional group is governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R. Under the terms of this Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020). However, prior to issuing a remand for the group, the Board finds a jurisdictional impediment with regard to the two participants in the group. The background of the case, the pertinent facts with regard to the two participants and the Board's determination are set forth below.

Background:

The QRS 2007 Medicaid Fraction Part C optional group appeal request was filed by Quality Reimbursement Services ("QRS") on October 28, 2019. The group was fully formed on October 28, 2020 with two participants that both filed from revised Notices of Program Reimbursement ("RNPRs"):

- Regional Health Rapid City Hospital (Prov. No. 43-0077) ("Rapid City") which was directly added and
- Indian River Memorial Hospital (Prov. No. 10-0105) ("Indian River") which transferred to the group from Case No. 19-2386

On March 12, 2021, the Medicare Contractor objected to the Board's jurisdiction over the group because neither participant had an adjustment to Medicaid Fraction Part C days in their RNPR.

A. Pertinent Facts for Rapid City

The Notice of Reopening dated April 5, 2019 states the cost report was reopened "[t]o adjust the SSI ratio based on the final SSI ratio ***provided from the Settlement Agreement*** and amend the Disproportionate Share Adjustment to account for the change in the SSI Ratio."[1]

On April 30, 2019, the Medicare Contractor issued the RNPR. The Provider referenced Audit Adjustment No. 4 which was made "[t]o include the latest finalized settlement data on the cost report[,] 42 CFR 413.64[,] CMS Pub. 15-1 Sec. 2408.2" and the settlement changed from the "previous value" of "0" to the "new value" of "527,997." However, there was no adjustment to the SSI fraction in either Audit Adjustment No. 4 or any of the other 3 audit adjustments listed in the report.[2]

Rapid City was directly added to the group when it was formed on October 28, 2019.[3]

B. Pertinent Facts for Indian River

The RNPR dated February 18, 2019 was issued as a result of the Board's 1498R remand previously issued on April 16, 2013. The Provider referenced Audit Adjustment No. 6 which was "[t]o update SSI ratio and adjust the DSH Percentage accordingly." However, the SSI percentage did not change as the "previous value" of "3.51" remained as reflected in the "0.00" "difference."

Indian River filed an individual appeal on August 8, 2019 to which the Board assigned Case No. 19-2386. The appeal included the Medicaid Fraction Part C days issue (in addition to two other issues). The Medicaid Fraction Part C days issue was transferred to the subject group when it was formed on October 28, 2019. (The other two issues were also transferred to groups resulting in the closure of the individual appeal on October 28, 2019).

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the

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[1] (Emphasis added.)

[2] There were only three other adjustments and none of these had values associated with them. Audit Adjustment Nos. 1 through 3 were for "[completed cost reporting forms and pages in accordance with current regulations," [c]orrected mathematical and flow through errors in cost reporting forms and pages as necessary," and "[t]o determine whether total Program reimbursement costs exceed total Program charges, and if so, to restrict the reimbursement to the lower of cost or charges."

[3] Rapid City also filed in the QRS CY 2007 DSH SSI Fraction Medicare Managed Care Part C Days (4) Group, Case No. 20-1675G on May 14, 2020. This group was dismissed by the Board on December 2, 2020 because both Providers in the optional group filed from RNPRs that did not adjust the SSI Fraction Part C Days issue. (The other provider in the SSI Fraction Part C Group, Harrison Medical Center, is not a participant in the Medicaid Fraction Part C days group).

amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

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

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

Accordingly, pursuant to 42 C.F.R. § 405.1889(b) (and § 405.1835(a)(1) which references that regulation), the Board has jurisdiction only over those matters that have been "specifically revised" in a revised determination. More specifically, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4]

Here, the Board finds that it does not have jurisdiction over Rapid City and Indian River as participants in this group. The Providers both appealed from RNPRs, but neither RNPR "specifically revised" or adjusted the Part C days issue, much less the SSI fraction where such days are required to be used by regulation in calculating the DSH adjustment calculation.

[4] 42 C.F.R. § 405.1889(b)(1).

A. Rapid City

Rapid City provided evidence that, on April 5, 2019, there was a reopening "[t]o adjust the SSI ratio based on the final SSI ratio provided ***from the Settlement Agreement***."[5] However, the Audit Adjustment Report for the RNPR dated April 17, 2019 does not include any adjustment to Part C Days much less to the SSI fraction. Rather, there is only a generic audit adjustment "[t]o include the latest finalized settlement data on the cost report[,] 42 CFR 413.64[,] CMS Pub. 15-1 Sec. 2408.2."[6] 42 C.F.R. § 405.1835(b) and 405.1837(a)(1) must demonstrate that it satisfies the requirements for a Board hearing under § 405.1835(a) which specifically references § 405.1889(b).[7] Here, the Provider has failed to establish that the Part C Days issue under appeal was specifically adjusted.

Finally, the Board notes that Rapid City did not provide the Board with a copy of the "Settlement Agreement" referenced in the reopening. The Board notes that the words "Settlement Agreement" rather than "administrative resolution" was used. This suggests that the Rapid City had agreed to "fully" settle the matter(s) in the Settlement Agreement. As a result, without seeing the Settlement Agreement, the Board must presume that the Settlement Agreement otherwise precluded Rapid City from appealing the matters settled therein and/or that the terms of the Settlement Agreement otherwise preclude Rapid City from being "dissatisfied" with the matters settled therein.

Accordingly, if Rapid City Indian River wished to appeal or contest the Part C days issue for FY 2007, they should have appealed the issue from their original NPRs when they clearly had the right to do so since appeals of any potential future RNPRs are limited to matters "specifically revised."[8] In making this statement, the Board is: (1) merely presuming that Rapid City has not previously appealed the Part C Days issue because Board Rules preclude duplicate appeals (*i.e.*, appealing same issue and year in separate appeals); and (2) the Board

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[5] (Emphasis added.)

[6] Note that the citation to the C.F.R. relates to payments to provider in general (*e.g.,* interim payments, retroactive payments, accelerated payments, interest payments resulting from judicial review) and the citation to the PRM relates to tentative settlements. As such, these citations are ***not*** related to DSH much less the SSI fraction.

[7] *See also* Board Rules 7.1.2.1. 21.2.2.

[8] For context, the Board takes administrative notice that:

1. The final rule establishing the Agency's current policy on treatment of Part C days in the SSI fraction (and the one at issue in this case) was issued on August 11, 2004 and the Agency's Part C days policy, both prior to and following the August 11, 2004 final rule, has been subject to much litigation. *See, e.g.*, *Northeast Hosp. Corp.v. Sebelius*, 699. Supp. 2d 81 (D.D.C. 2010), *aff'd by*, 657 F.3d 1 (D.C. Cir. 2011); *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012), *aff'd by*, 746 F.3d 1102 (D.C. Cir. 2014); *King & Spalding Inclusion of Medicare Advantage Days in 2007 SSI Ratios v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D38 (June 29, 2010) (This "D-" decision is an EJR determination. The Board does not routinely publish EJR determinations as "D-" decisions and will do so only when the EJR determination is *seminal*.).
2. Most providers filing Board appeals of the Part C days issue have done so by appealing from their original NPR, regardless of whether that NPR was issued prior to or after 1498-R (including certain appeals filed pre- 2010 in which the provider later requested bifurcation of the Part C days issue from dual eligible days issues emanating from the same August 11, 2004 final rule).

is ***not*** finding that Rapid City has previously appealed the Part C days issue from the same or different determination as the Board does not have the means to review all prior and current individual and group appeals filed with the Board.

B. Indian River

Similarly, the RNPR issued for Indian River did not "specifically revise" or adjust the SSI fraction as used in the DSH calculation. The Board recognizes that Indian River's RNPR apparently was issued as a result of a 1498-R remand. However the fact that CMS Ruling 1498-R may have prompted the reopening and issuance of the RNPR has no bearing here. The three components, or issues, of the SSI fraction addressed by 1498-R and for which 1498-R "eliminate[d] any actual case or controversy" were:

1. "*[T]he Data Matching Process Used in Calculating the SSI Fraction*." The Ruling applied to then-pending appeals of this issue "challenging CMS's data matching process, which the agency uses in determining the SSI fraction by matching Medicare and SSI eligibility data." The seminal case dealing with this issue is *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008). As a result, this issue is sometimes referred to as the *Baystate* SSI data matching issue.

2. "*[T]he Exclusion from the DPP [i.e., disproportionate share percentage] of Non-Covered Inpatient Hospital Days for Patients Entitled to Medicare Part A, and Days for Which the Patient's Part A Inpatient Hospital Benefits were Exhausted*." The Ruling applied to "cost reports with discharges before October 1, 2004" for which hospitals have pending "appeals seeking inclusion in the DPP of inpatient days where the patient was entitled to Medicare Part A but the inpatient hospital stay was not covered under Part A" (e.g., exhausted days and Medicare secondary payor ("MSP") days).

3. "*[T]he Exclusion from the DPP of Labor/Delivery Room ["LDR"] Inpatient Days*." The Ruling applied to "cost reporting periods beginning before October 1, 2009" for which hospitals have pending appeals "seeking inclusion of LDR inpatient days in the DPP regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour."

The only issues covered by Ruling 1498-R that could be applicable to Indian River for FY 2007 are the Baystate data match process issue or Labor/Delivery Room Days. Neither of these issues cover or include the Part C days issue.[9] Accordingly, it is clear that Ruling 1498-R

[9] In other words, a provider could appeal the Part C days issue from their original NPR and CMS Ruling 1498-R did not impact any Part C Days appeals. Here, it appears as if Indian River opted not to appeal the Part C days issue from its original NPR for FY 2007.

did ***not*** apply to SSI Medicare Part C days issues and, thus, the SSI Medicare Part C Days issue was outside the scope of Ruling 1498-R.[10]

The Board further recognizes that Ruling 1498-R states that a RNPR issued following a 1498-R remand ***of the Baystate SSI data matching issue*** "will be subject to administrative and judicial review in accordance with the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines." However, "the applicable jurisdictional and procedural requirements of . . . the Medicare regulations" includes 42 C.F.R. § 405.1889 and, as discussed above, this regulation limits Board jurisdiction to "those matters that are specifically revised." Here, it is clear that the Part C days issue was both outside the scope of 1498-R and not "specifically" revised in the RNPR at issue for Indian River.[11]

The only manner in which the Board has determined that it has jurisdiction over the Part C days issue *in the context of a RNPR* is if: (1) the SSI percentage is specifically adjusted for Part C Days; ***or*** (2) the data match process is rerun and generates a new and different SSI percentage where the Board must necessarily assume that there was a change in the underlying month-by-month data and that the Part C days included in that month-by-month data also were changed.[12] Here, the SSI percentages clearly were not adjusted for Part C days and, unless there is evidence to the contrary (which there is not), the Board must presume the underlying Part C days data was not changed since there were no changes in the SSI

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[10] *See* CMS Ruling 1498-R at 18 (stating: "[I]f the administrative tribunal finds that a given claim is outside the scope of the Ruling (because such claim is not for one of the three DSH issues) or the claim fails to meet the applicable jurisdictional and procedural requirements for relief under the Ruling, then the appeals tribunal will issue a written order, briefly explaining why the tribunal found that such claim is not subject to the Ruling. The appeals tribunal will then process the provider's original appeal of the same claim in accordance with the tribunal's usual, generally applicable appeal procedures.").

[11] Further, the Board notes that, if the issue in this appeal had pertained to the *Baystate* data match process issue (as opposed to the Medicaid Fraction Part C days issue), the situation would be very different and the Board would have jurisdiction over it pursuant to Ruling 1498-R and 42 C.F.R. § 405.1889(b). In that scenario, while the provider's RNPR would have no adjustments, the provider would be trying to resume their original PRRB appeal of the *Baystate* SSI data match process issue (which the Ruling had eliminated and required the Board to remand) and would be dissatisfied with the intervening application of a new data match process (as mandated by Ruling 1498-R) that did not change their SSI fraction (*i.e*, they would be dissatisfied that the mandated new data matching process did not result in a change to their SSI fraction due to flaws in that new data matching process).

[12] This second situation does ***not*** encompass a realignment of the SSI percentage because CMS does ***not*** rerun the data match process in order to effectuate a realignment but rather uses pre-existing data previously gathered on a month-by-month basis to effectuate the realignment. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis); 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

percentages themselves.[13] Accordingly, if Indian River wished to appeal or contest the Part C days issue for FY 2007, they should have appealed the issue from their original NPRs when they clearly had the right to do so since appeals of any potential future RNPRs are limited to matters "specifically revised."[14] Again, in making this statement, the Board is: (1) merely presuming that Indian River has not previously appealed the Part C Days issue because Board Rules preclude duplicate appeals (*i.e.*, appealing same issue and year in separate appeals); and (2) the Board is ***not*** finding that Rapid City has previously appealed the Part C days issue from the same or different determination as the Board does not have the means to review all prior and current individual and group appeals filed with the Board.

Finally, the Board notes that the 1498-R Remand included in the record was issued on April 16, 2013 and that the RNPR at issue was issued *almost 6 years later* on February 18, 2019. It is unclear if there were any RNPRs issued during that 6 year period and, if so, whether the SSI fraction to which the remand applied was otherwise revised at an earlier time. In this regard, the Board Rule 7.1.2.2 (as also referenced in and incorporated into Board Rule 21.2.2) requires a provider appealing from an RNRP to "identify the issuance dates of the original NPR and all prior revised NPRs." However, Indian River failed to furnish this information. Indeed, to further highlight the import of that information, the Board takes administrative notice that, through its docket, it is aware of situations in which a provider was subject to a 1498-R remand but, *prior to that remand being effectuated*, the provider received an unrelated reopening and was issued a RNPR with the new SSI percentage resulting from the new data match process, thereby rendering the later 1498-R effectuation perfunctory with a "0.00" adjustment.

* * * * *

In summary, because there were no revisions to the SSI percentages for either Provider, the audit adjustments associated with the RNPRs do not meet the requirements of the regulation

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[13] The Board is aware of situations in which a provider was subject to a 1498-R remand but, *prior to that remand being effectuated*, the provider received an unrelated reopening and was issued a RNPR with the new SSI percentage resulting from the new data match process, thereby rendering the later 1498-R effectuation perfunctory with a "0.00" adjustment.

[14] For context, the Board takes administrative notice that:

1. The final rule establishing the Agency's current policy on treatment of Part C days in the SSI fraction (and the one at issue in this case) was issued on August 11, 2004 and the Agency's Part C days policy, both prior to and following the August 11, 2004 final rule, has been subject to much litigation. *See, e.g.*, *Northeast Hosp. Corp.v. Sebelius*, 699. Supp. 2d 81 (D.D.C. 2010), *aff'd by*, 657 F.3d 1 (D.C. Cir. 2011); *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012), *aff'd by*, 746 F.3d 1102 (D.C. Cir. 2014); *King & Spalding Inclusion of Medicare Advantage Days in 2007 SSI Ratios v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D38 (June 29, 2010) (This "D-" decision is an EJR determination. The Board does not routinely publish EJR determinations as "D-" decisions and will do so only when the EJR determination is *seminal*.).
2. Most providers filing Board appeals of the Part C days issue have done so by appealing from their original NPR, regardless of whether that NPR was issued prior to or after 1498-R (including certain appeals filed pre- 2010 in which the provider later requested bifurcation of the Part C days issue from dual eligible days issues emanating from the same August 11, 2004 final rule).

for Board jurisdiction of matters revised in a RNPR and the Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1). The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[15] Therefore, the Board dismisses Rapid City and Indian River from the group pursuant to 42 C.F.R. § 405.1889. As there are no other participants in the group, the Board closes Case No. 20-0243G and removes it from the docket.

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

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

For the Board:

6/28/2021

X Clayton J. Nix

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

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

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